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Illinois Medical Journal

OFFICIAL JOURNAL OF THE ILLINOIS STATE MEDICAL SOCIETY

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HIGHLIGHTS OF CONVENTION

Summary of Actions
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of Delegates
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Flagyl[®]

brand of

metronidazole

simplifies

vaginitis

therapy

The effectiveness of Flagyl in *Trichomonas vaginalis* vaginitis has been so constant that use of less effective agents would seem to invite unnecessary failures. ■ The simplicity, completeness and persistence of cures with Flagyl qualify it as the logical first therapeutic choice in trichomonal infections.

- simple** Ten-day treatment with Flagyl oral tablets has replaced a multitude of untidy douches, powders, creams and jellies.
- complete** Flagyl is the only medication available that is able to reach all the crypts, glands and cavities of the female urogenital system as well as reservoirs of reinfection in male trichomonas carriers.
- lasting** Flagyl eradicates resistant, deep-seated invasions of *Trichomonas vaginalis* and consistently produces cure rates above 90 per cent and often as high as 100 per cent in large series of patients. When the diagnosis is positive, Flagyl is positive.

Indications: For the treatment of trichomoniasis in both male and female patients and the sexual partners of patients with a recurrence of the infection provided trichomonads have been demonstrated by wet smear or culture. ■ **Contraindications:** Evidence of or a history of blood dyscrasia, in patients with active organic disease of the central nervous system, and the first trimester of pregnancy. ■ **Warnings:** Use with discretion during the second and third trimesters of pregnancy and restrict to patients not cured by topical measures. Flagyl is secreted in the breast milk of nursing mothers; it is not known whether this can be injurious to the newborn. ■ **Precautions:** Mild leukopenia has been reported during Flagyl use; total and differential leukocyte counts are recommended before and after treatment with the drug, especially if a second course is necessary. Avoid alcoholic beverages during Flagyl therapy because abdominal cramps, vomiting and flushing may occur. Discontinue Flagyl promptly if abnormal neurologic signs occur. There is no accepted proof that Flagyl is effective against other organisms and it should not be used in the treatment of other conditions. Exacerbation of moniliasis may occur. ■ **Adverse Reactions:** Nausea, headache, anorexia, vomiting, diarrhea, epigastric distress, abdominal cramping, constipation, a metallic, sharp and unpleasant taste, furry or sore tongue, glossitis and stomatitis possibly associated with a sudden overgrowth of *Monilia*, exacerbation of vaginal moniliasis, an occasional reversible moderate leukopenia, dizziness, vertigo, drowsiness, incoordination and ataxia, numbness or paresthesia of an extremity, fleeting joint pains, confusion, irritability, depression, insomnia, mild erythematous eruptions, "weakness," urticaria, flushing, dryness of the mouth, vagina or vulva, vaginal burning, pruritus, dysuria, cystitis, a sense of pelvic pressure, dyspareunia, fever, polyuria, incontinence, decrease of libido, nasal congestion, proctitis, pyuria and darkened urine have occurred in patients receiving the drug. Patients receiving Flagyl may experience abdominal distress, nausea, vomiting or headache if alcoholic beverages are consumed. The taste of alcoholic beverages may also be modified. ■ **Dosage and Administration:** *In the Female.* One 250-mg. tablet orally three times daily for ten days. Courses may be repeated if required in especially stubborn cases; in such patients an interval of four to six weeks between courses and total and differential leukocyte counts before, during and after treatment are recommended. Vaginal inserts of 500 mg. are available for use, particularly in stubborn cases. *When the vaginal inserts are used,* one 500-mg. insert is placed high in the vaginal vault each day for ten days and the oral dosage is reduced to two 250-mg. tablets daily during the ten-day course of treatment. Do not use the vaginal inserts as the sole form of therapy. *In the Male.* Prescribe Flagyl only when trichomonads are demonstrated in the urogenital tract, one 250-mg. tablet two times daily for ten days. Flagyl should be taken by both partners over the same ten-day period when it is prescribed for the male in conjunction with the treatment of his female partner. ■ **Dosage Forms:** Oral tablets.....250 mg. Vaginal inserts.....500 mg.

G. D. SEARLE & CO.

Research in the Service of Medicine

Illinois Medical Journal

volume 138, number 1

july, 1970

IIMJ

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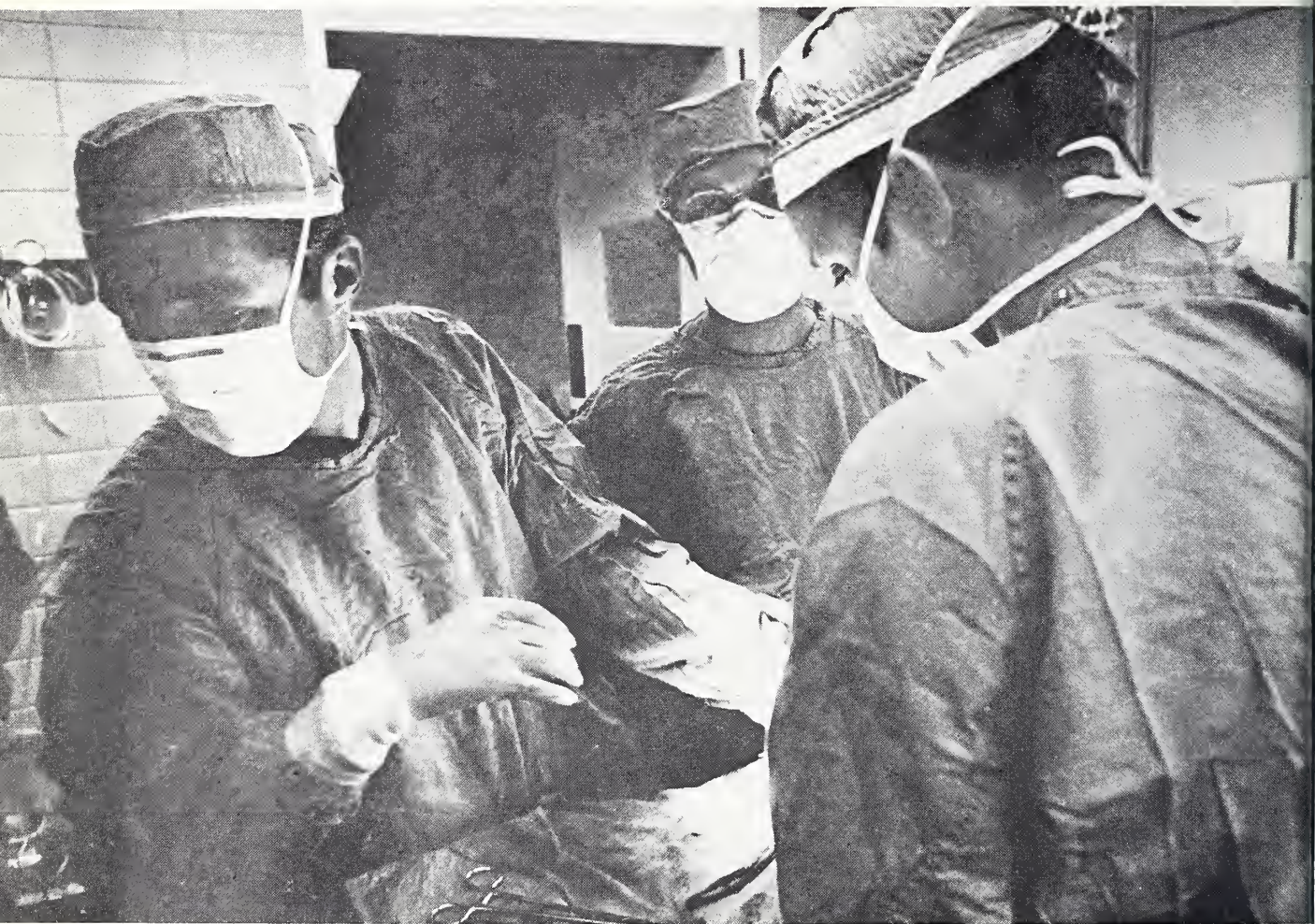
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BLUE SHIELD REPORT



FOR *Illinois Physicians*



Blue Shield Board Members Elected to High AMA Posts

Walter C. Bornemeier, M.D., Chicago, a Trustee of Illinois Blue Shield, became the 125th President of the American Medical Association and was inaugurated at its annual meeting Wednesday, June 24, in the Grand Ballroom of the Palmer House. Dr. Burtis E. Montgomery, Chairman of the American Medical Association's Board of Trustees and also a Trustee of Illinois Blue Shield administered the oath of office.

Dr. Bornemeier has served on the Board of Trustees of the Blue Shield Plan of Illinois Medical Service since 1953. In 1963 he was elected Vice-Speaker of the AMA House and was elected Speaker in 1966.

Burtis E. Montgomery, M.D., Harrisburg, has served on the American Medical Association Board since 1966 and on the Board of Trustees of Blue Shield since 1958. He was President of the Illinois State Medical Society in 1966 and was Chairman of its Board of Trustees from 1958 to 1960.

Dr. Bornemeier, left, and Dr. Montgomery, right, are shown in the above photograph during the inauguration ceremony.

Why Some Blue Shield Claims Are Delayed

A study of Blue Shield claims has been made to determine the reasons why payments have been delayed and to help us make payments to physicians more promptly.

The primary cause for delay in Blue Shield payments is due to incomplete information on the Blue Shield Physician's Service Report form.

In order to speed payments to you, it is necessary for us to have the following information.

On anesthesia claims, please provide the following information on the Blue Shield claim form.

- (a) The time of the anesthesia
- (b) The charge for anesthesia
- (c) Particular attention should be given to claims submitted for anesthesia administered during a dilation and curettage of the uterus. Please indicate whether the procedure was performed for obstetrical purposes. It is suggested that you either provide the diagnosis or simply state Dilation and Curettage "obstetrical" or "non-obstetrical". This is necessary because of the high volume of claims submitted for this procedure.

On claims submitted for surgical procedures, please include the following information on the Blue Shield Physician's Service Report form.

- (a) Itemization of all charges.

This is particularly important in order to make payment to physicians on the basis of their Usual and Customary charges for Blue Shield members who are protected by our Usual and Customary program.

- (b) When reporting surgical procedures, please do not use such names as, "Strassman procedure" or "Nissen procedure". Payments will be made more promptly if you use standard medical nomenclature.

Claims for radiation therapy are often delayed because the diagnosis is not included on the Physician's Service Report. By reviewing the claims before they are submitted to Blue Shield unnecessary delay can be prevented and the necessity to contact you or your medical assistant for additional information can be avoided.

ASK BLUE SHIELD

• • • ABOUT MEDICARE

Services in an Extended Care Facility

Because misunderstandings still exist over payments for services in Extended Care Facilities, we have undertaken a series of articles which began in the May issue of the Illinois Medical Journal to inform Illinois physicians of covered services paid for by Medicare so they will be in a better position to advise their patients that some services may not be covered and alternative financing arrangements may have to be made.

Examples of covered Medicare services in Extended Care Facilities are continued in this report.

Braces and similar devices:—Routine care in connection with such appliances would not constitute skilled services. Training in the proper use of a particular appliance should be evaluated in relation to the need for physical therapy.

Heat treatments:—The therapeutic use of sun lamps, infrared lamps, diathermy and similar equipment constitutes skilled care when:

1. the service is specifically ordered by a physician as part of an active treatment regimen; and
2. the observation by skilled personnel is required in order to evaluate adequately the results of the treatment and inform the physician of the patient's progress.

Use of such equipment for palliative purposes or comfort is not a skilled service and would not be a Medicare benefit.

Restraints:—The use of protective restraints such as bed rails, soft binders and supports for wheel chair patients generally does not require the services of skilled personnel.

Administration of medical gas:—Any regimen requiring the administration of medical gases would be started only upon the physician's order. The initial phase of such a regimen would be skilled care. However, when the administration becomes routine, it would not generally be considered a skilled service because patients can usually be taught to operate their own inhalation equipment.

Restorative nursing:—Restorative nursing procedures constitute skilled services when they are prescribed by a physician, are designed to restore functions which have been lost or reduced by illness or injury, and are a type whose performance requires the presence of licensed nurses. In many instances, such procedures would be an adjunct to an intensive program of physical therapy.

When a patient has reached his restoration potential, the services required to maintain him at this level generally would not constitute skilled nursing care, nor would supervision of exercises which have been taught to the patient be considered skilled services.

Physical therapy, one aspect of restorative care, consists of the application of a complex and sophisticated group of physical modalities and therapeutic services. Physical therapy, therefore, is a skilled service. Because the statute defines extended care as skilled nursing care on a continuing basis, provision of physical therapy only would not justify a finding that the patient requires extended care. In some situations, a patient whose primary need is for physical therapy will also require sufficient skilled nursing to meet the definition of extended care. The need for such supportive skilled nursing on a continuing basis may be presumed when:

1. the therapy is directed by the physician who determines the need for therapy, the capacity and tolerance of the patient, and the treatment objectives; and
2. the physician, in consultation with the therapist, prescribes the specific modalities to be used and frequency of therapy services; and
3. the therapy is rendered by or under the supervision of a physical therapist who meets the qualifications established by regulations; when the qualified therapist is the supervisor, he is available and on the premises of the facility while the therapy is being given, he makes regular and frequent evaluations of the patient, records findings on the patient's chart, and communicates with the physician as indicated; and
4. the therapy is for the restoration of a lost or impaired function. For example, frequent physical therapy treatments in connection with a fractured back or hip or a CVA can be presumed to be directed toward restoration of lost or impaired function during the early phase—when physical therapy can be presumed to be effective. However, when the condition has been stabilized, the presumption that continuing supportive skilled nursing services are required is no longer valid. Such cases must be evaluated in relation to the specific amount of skilled nursing attention required in the individual case and supported by the physician's orders and nursing notes.

The discussion of services in extended care facilities will be continued in the next issue of this report.

Notice of changes in Certification

The Social Security Administration has announced that Medicare can reimburse for selected laboratory procedures performed by the following laboratory:
Colton Microbiology Laboratory
555 North Monroe
Hinsdale, Illinois 60521



J. Ernest Breed

The President's Page

Responsibility

The responsibility for the health of all the people in the United States is still the privilege of the American medical profession, but, as the problems become more complex, others loudly proclaim the need for a change in management. The difficulties we face are profound—the increasing cost, the increasing number of required services, the need for increasing numbers of assistants with diverse skills, the declaration of health care as a right, the increasing demands by those previously uninformed as they learn health for them is possible, the fractionation of the profession into specialties and subspecialties—all of these and many other factors compound our problem. Of course, if we wish to abdicate, others would be glad to relieve us of control over the health team.

Since few of us would forsake our calling, we in the Medical Society plan to proceed in all manners possible to discharge our responsibilities to the public.

As outlined in my inaugural address, four areas require priority in our immediate activities.

In **Continuing Education** we plan to cooperate with the University of Illinois and other schools to establish the most feasible methods to assist physicians in keeping up with the rapid changes in scientific knowledge. We also hope to place emphasis on the "art" of medicine, since it does little good to have the correct diag-

nosis if the patient refuses to accept it or the prescribed treatment.

Peer Review not only is necessary as a third party requirement, but it serves as a subconscious stimulant to keep members abreast of new techniques. It also serves as a guarantee of quality care for the patient and protects the physicians from unjust accusations.

Malpractice claim increases require a defensive crash program which we hope to inaugurate soon. It involves the provision of a panel of experts for screening threatened suits. It is hoped this procedure will fractionate the number of claims.

Changes In the Health Care Delivery System are designed to take advantage of modern, efficient business methods, the use of allied health assistants, computers, modern methods of communication, etc. You will hear much more of this later, but it is obvious to all that adequate numbers of young general practitioners required to replace our rapidly retiring older family physicians are just not going to be available.

If we are going to discharge the responsibilities as guardians of the public health then we must be realistic and adopt technical changes in the delivery of health care that will permit us to do the job.

Newsreel Classics

By M. W. MARTIN/OHIO

"The death of the patient terminates the physician-patient relationship."

Ohio State Medical Journal

"First draft call for sex comes to women doctors."

Russellville Courier-Democrat

"As to the heart condition, a result of the accident, Dr. Stahl stated that while she will probably always have this ailment, it will not, in his opinion, always be permanent."

Hutchinson News-Herald

"Mr. Ringling eats sparingly; smokes denicotinized cigars, takes daily exercises and until the beginning of this illness was able to touch the floor with his finger tips without bending."

New York Times

"'But,' Dr. Harrison says, 'we're happy to get cadavers at any price and we'll settle for a change in legislature that will help to maintain an adequate supply.'"

Norway Advertiser

"William Sorensen returned home yesterday from the hospital, where his left leg was placed in a cast following a fracture of the right ankle."

Auburn Star

"The bandits demanded heavy ransom for their release, threatening to cut off their heads and then put them to death if the money was not forthcoming."

Toledo Blade

"The district has no figures as to the number of married students who are pregnant. Almost all of them are girls."

Jackson State Times

"Miami man admits taking his own life."

Oakland Tribune

"His face still patched with adhesive plaster, Winston Churchill today was taken to the Waldorf Astoria Hotel and was immediately put to bed under his nurse and with his wife and daughter."

Genesee Livingston-Republican

"A sixty-five-year-old male with proven eosinophilic gastroenteritis was followed for nearly seven years."

JAMA

"City youths brought to county jail following post-mortem statement of dead bandit."

Chicago Tribune

Brief Summary of Prescribing Information—9-9/22/69. For complete information consult Official Package Circular.

Indications: Essential hypertension. Use cautiously in patients with renal insufficiency, particularly if they are digitalized.

Contraindications: Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.

Warnings: Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distension, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients. **Use in Pregnancy:** Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.

Precautions: Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokalemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss or protoveratrine A may cause digitalis intoxication. **Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy. Stop therapy if protoveratrine A induces digitalis intoxication.** Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease or bronchial asthma and in those with a history of peptic ulceration or bronchial asthma; in post-sympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.

Adverse Reactions: Hydroflumethiazide: Skin rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. **Reserpine:** Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares. **Protoveratrine A:** Nausea, vomiting, cardiac arrhythmia, prostration, blurring vision, mental confusion, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)

Usual Dose: 1 tablet b.i.d.

Supplied: Bottles of 60, 600, and 1000 scored 50 mg. tablets.

Salutensin®

hydroflumethiazide, 50 mg./reserpine,
0.125 mg. protoveratrine A, 0.2 mg.

BRISTOL

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ther days she doesn't even try

the treatment of depression, Aventyl HCl as part of your total therapy often brings early symptomatic improvement.

Aventyl HCl aids in renewing motor function and increasing interest in life. Patients may report that they eat more, enjoy disturbed sleep . . . generally begin to function better. Relief from their most distressing symptoms helps them "open up" and ventilate their problems.

n depression

AVENTYL® HCl NORTRIPTYLINE HYDROCHLORIDE

Indications: Aventyl HCl is indicated for the relief of symptoms of depression. Endogenous depressions are more likely to be alleviated than are other depressive states.

Contraindications: The use of Aventyl HCl or other tricyclic antidepressants concurrently with a monoamine oxidase (MAO) inhibitor is contraindicated. Hyperpyretic crises, convulsions, and fatalities have occurred when simvastatin and tricyclic antidepressants were used in such combinations. Discontinue the MAO inhibitor for at least two weeks before beginning treatment with Aventyl HCl. Patients hypersensitive to nortriptyline HCl should not be given the drug. Cross-sensitivity between Aventyl HCl and other dibenzazepines is a possibility.

Aventyl HCl is contraindicated during the acute recovery period after myocardial infarction.

Warnings: Cardiovascular patients should be supervised closely because of the tendency of Aventyl HCl to produce tachycardia and to prolong the conduction time. Myocardial infarction, arrhythmia, and strokes have occurred. The antihypertensive action of guanethidine and other agents may be blocked. Because of its anticholinergic activity, Aventyl HCl should be used with great caution in patients with glaucoma or a history of urinary retention. Patients with a history of seizures should be followed closely, since this drug is known to lower the convulsive threshold. Great care is required if Aventyl HCl is administered to hyperthyroid patients or to those receiving thyroid medication, since cardiac arrhythmias may develop.

Use in Pregnancy: Safe use of Aventyl HCl during pregnancy and lactation has not been established; therefore, the potential benefits of administration to pregnant patients, nursing mothers, or women of childbearing potential must be weighed against the possible hazards.

Use in Children: This drug is not recommended for use in children, since safety and effectiveness in the pediatric age group have not been established.

Aventyl HCl may impair the mental and/or physical abilities required for the performance of hazardous tasks, such as operating machinery or driving a car; therefore, patients should be warned accordingly.

Precautions: Aventyl HCl in schizophrenic patients may result in an exacerbation of the psychosis or may activate latent schizophrenic symptoms. In overactive or agitated patients, increased anxiety and agitation may occur. In melancholic depressive patients, Aventyl HCl may cause symptoms of the manic phase to emerge.

Unpleasant patient hostility may be aroused by the use of Aventyl HCl. Epileptiform seizures may accompany its administration, as is true of other drugs of its class.

Close supervision and careful adjustment of the dosage are required when Aventyl HCl is used with other anticholinergic drugs and sympathomimetic drugs.

The patient should be informed that the response to alcohol may be exaggerated.

When necessary, the drug may be administered with electroconvulsive therapy, although the hazards may be increased. Discontinue the drug for several days, if possible, prior to elective surgery.

Because the possibility of a suicidal attempt by depressed patients remains after the initiation of treatment, dispense the least possible quantity of drug at any given time.

Both elevation and lowering of blood sugar levels have been reported.

Adverse Reactions: Note: Included in the following list are a few adverse reactions which have not been reported with this specific drug. However, the pharmacologic similarities among the tricyclic antidepressant drugs require that each of the reactions be considered when nortriptyline is administered.

Cardiovascular: Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Confusional states (especially in the elderly) with hallucinations, disorientation, delusions; anxiety, restlessness, agitation; insomnia, panic, and nightmares; hypomania; exacerbation of psychosis.

Neurological: Numbness, tingling, paresthesias of extremities; inco-ordination, ataxia, tremors; peripheral neuropathy; extrapyramidal symptoms; seizures, alteration in EEG patterns; tinnitus.

Anticholinergic: Dry mouth and, rarely, associated sublingual adenitis; blurred vision, disturbance of accommodation, mydriasis; constipation, paralytic ileus; urinary retention, delayed micturition, dilation of the urinary tract.

Allergic: Skin rash, petechiae, urticaria, itching, photosensitization (avoid excessive exposure to sunlight); edema (general or of face and tongue); drug fever, cross-sensitivity with other tricyclic drugs.

Hematologic: Bone-marrow depression, including agranulocytosis; eosinophilia; purpura; thrombocytopenia. **Gastro-intestinal:** Nausea and vomiting, anorexia, epigastric distress, diarrhea; peculiar taste, stomatitis, abdominal cramps, blacktongue.

Endocrine: Gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido, impotence; testicular swelling; elevation or depression of blood sugar levels.

Other: Jaundice (simulating obstructive); altered liver function; weight gain or loss; perspiration; flushing; urinary

frequency, nocturia; drowsiness, dizziness, weakness, and fatigue; headache; parotid swelling; alopecia.

Withdrawal Symptoms: Though these are not indicative of addiction, abrupt cessation of treatment after prolonged therapy may produce nausea, headache, and malaise.

Administration and Dosage: Aventyl HCl is not recommended for children.

Aventyl HCl is administered orally in the form of Pulvules® or liquid. Lower dosages are recommended for elderly patients, adolescents, and outpatients not under close supervision. Start dosage at a low level and increase gradually, noting carefully the clinical response and any evidence of intolerance. Following remission, maintenance medication may be required for a prolonged period at the lowest effective dose.

If a patient develops minor side-effects, reduce the dosage. Discontinue the drug promptly if serious adverse effects or allergic manifestations occur.

Usual Adult Dose: 25 mg. three or four times daily, starting at a low level and increasing as required. Doses above 100 mg. per day are not recommended.

Elderly and Adolescent Patients: 30 to 50 mg. per day, in divided doses.

Overdosage: Toxic overdosage may result in confusion, restlessness, agitation, vomiting, hyperpyrexia, muscle rigidity, hyperactive reflexes, tachycardia, ECG evidence of impaired conduction, shock, congestive heart failure, stupor, coma, and C.N.S. stimulation with convulsions followed by respiratory depression. Deaths have occurred following overdosage with drugs of this class.

No specific antidote is known. General supportive measures are indicated, with gastric lavage. Respiratory assistance is apparently the most effective measure when indicated. The use of C.N.S. depressants may worsen the prognosis.

Barbiturates for control of convulsions alleviate an increase in the cardiac work load but should be used with caution to avoid potentiation of respiratory depression.

Intramuscular paraldehyde or, preferably, diazepam provides anticonvulsant activity with less respiratory depression than do the barbiturates.

Digitalis and/or pyridostigmine may be considered in serious cardiovascular abnormalities or cardiac failure.

The value of dialysis has not been established.

How Supplied: Liquid Aventyl® HCl (nortriptyline hydrochloride, Lilly), 10 mg. (equivalent to base) per 5 mL, in pint bottles.

Pulvules Aventyl HCl, 10 and 25 mg. (equivalent to base), in bottles of 100 and 500.

[040670]



Additional information available upon request.

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Clinics for Crippled Children Scheduled

Twenty clinics for Illinois' physically handicapped children have been scheduled for August by the University of Illinois, Division of Services for Crippled Children. The Division will hold 14 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical social, and nursing service. There will be five special clinics for children with cardiac conditions and rheumatic fever, and one for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

August 5—Carlinville—Carlinville Area Hospital
 August 5—Hinsdale—Hinsdale Sanitarium
 August 6—Lake County Cardiac—Victory Memorial Hospital
 August 11—Peoria—St. Francis Children's Hospital
 August 11—East St. Louis—Christian Welfare Hospital
 August 12—Champaign-Urbana—McKinley Hospital
 August 13—Springfield General—St. John's Hospital
 August 14—Chicago Heights Cardiac—St. James Hospital
 August 18—Belleville—St. Elizabeth's Hospital
 August 18—Rock Island Area General—Moline Public Hospital
 August 19—Chicago Heights General—St. James Hospital

August 20—Rockford—Rockford Memorial Hospital
 August 20—Bloomington—St. Joseph's Hospital
 August 20—Elmhurst Cardiac—Memorial Hospital of DuPage County
 August 24—Peoria Cardiac—St. Francis Children's Hospital
 August 25—Peoria—St. Francis Children's Hospital
 August 26—Aurora—Copley Memorial Hospital
 August 26—Springfield Pediatric Neurology—Diocesan Center
 August 28—Chicago Heights Cardiac—St. James Hospital
 August 28—Evanston—St. Francis Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

ON THE COVER

The expansion of medicine in terms of health care and knowledge is expressed in the brilliant colors surrounding the caduceus, which like the rays of the sun appear to be far-reaching, blending into the unknown.

The caduceus long recognized as the symbol of medicine consists of a staff of Aesculapius about which a single serpent is coiled.

The Medical Corps of the United States Army has modified the symbol to consist of a staff with two farnal wings at the top, and two separate serpents entwined about the remainder. The latter is not regarded as a medical, but as an administrative emblem, implying neutral, non-combatant status.

Abstracts Of Board Actions

Board of Trustees Meeting During Annual Convention

May 16-20, 1970

Sherman House Hotel, Chicago

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. It covers only major actions and is not intended as a detailed report. Full minutes of the meetings are available upon any member's request to the headquarters office of the ISMS.

Agreement with Third Party Carrier

Progress was reported by Dr. Edward Cannady in discussions with the Continental Casualty Company, regarding administration of Part B Medicare in 97 Illinois counties. The following agreements have been reached:

Inconsistencies of charges will be examined by the company and elimination of coding inconsistencies will be accomplished; form letters written to patients by the firm will be discussed with ISMS to eliminate obnoxious phrases; telephone calls to physicians will be curtailed as much as possible; physicians will be given opportunity to justify questioned bills.

Continuing Medical Education

Previous action of the Board of Trustees, requesting the House of Delegates to authorize a \$20 per member dues assessment in support of the continuing medical education program, was reconsidered. The action was based on information from Dr. George Miller, University of Illinois, that other medical schools would not be participants and that the program will largely be conducted by the University of Illinois. The Board will recommend, to the House of Delegates, enthusiastic support of the program, with ISMS participation, but financial support from ISMS will be deferred until a later date.

IMPAC Membership Records

The report of the treasurer showed that dues paying members recorded for the first quarter of 1970 totaled 8,304. Of these members, 44% had become contributors to IMPAC on a voluntary basis. The IMPAC 3rd District percentage was 36% and the remainder of the state 62% of the paid membership. The anticipated total paid members of the ISMS for the year is 9,350. Retired, emeritus and other categories will increase the total membership to about 10,500.

Meeting with Illinois Hospital Association

At a meeting between the Executive Committees of the ISMS and IHA it was agreed—

- to jointly update a handbook on the release of medical records previously published by the Illinois Medical Records Librarian Association
- to send a joint letter to hospitals, E.C.F.'s and

nursing homes regarding the proper use of physical therapy services

- to jointly study ways of reducing malpractice cases
- that IHA Executive Committee would distribute a letter to hospitals stating the Association's official position on physicians serving on hospital boards
- that the ISMS would keep the IHA informed of new developments in the use of physicians' assistants

CMS Funds for Benevolence Care

All recipients of ISMS benevolence from the 3rd District will be paid from a fund at CMS, established at the bequest of one of the past presidents of the State Society Auxiliary. This procedure will be followed after July 1, 1970, and continue as long as funds are available from this source. Payments to most of the benevolence recipients will be increased effective July 1, 1970.

School Bus Driver Physicals

Many school districts, under existing local option, do not require physical examinations for school bus drivers. The Board acted to refer this matter to the Committee on Public Safety for study and recommendations for subsequent action.

Peer Review Guidelines

The Board reviewed further refinements made in the Peer Review Guidelines by the interim peer review committee. Several changes in wording were suggested. The Guidelines will be published in final form and be distributed to county societies for their advice and guidance.

Annual Illinois Luncheon Cancelled

The ISMS will participate in honoring Dr. Walter C. Bornemeier as the in-coming President of the American Medical Association. The funds usually expended on the Illinois luncheon at the AMA meeting will be made available to assist in hosting the reception honoring Dr. Bornemeier on Wednesday evening, June 24. The reception will follow the inaugural services.

New Chairman of the Board Elected

At the post-convention Board meeting, Dr. Willard C. Scrivner, East St. Louis, was selected to follow Dr. Frank J. Jirka, Jr., River Forest, as Chairman of the Board. Dr. Edward W. Cannady, immediate past president was named to serve as Parliamentarian for the Board of Trustees.

Computerized Billing Service Approved

Upon recommendation of the Council on Economics and Governmental Health Programs, the computerized billing system for physicians, developed by Indecon, a Chicago based firm, was endorsed. Physicians who subscribe to this service will be invited to share fee data with the Council on Peer Review. Indecon is headed by Mr. William Love, formerly associated with Blue Shield.

(Continued on page 86)



Achrocidin® Tablets and Syrup

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen Citrate 25 mg.

ACHROCIDIN Tetracycline HCl—Antihistamine—Analgesic Compound Tablets and Syrup are recommended for the treatment of tetracycline-sensitive bacterial infection which may complicate vasomotor rhinitis, sinusitis and other allergic diseases of the upper respiratory tract, and for the concomitant symptomatic relief of headache and nasal congestion. For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN Tetracycline equivalent to tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons

on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculo-

popular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

NEW

PHARMACEUTICAL SPECIALTIES

by Paul deHaen

For detailed information regarding indications, dosage, contraindications, and adverse reactions, refer to the manufacturer's package insert or brochure.

Single Chemicals: Drugs not previously known, including new salts.

Duplicate Single Products: Drugs marketed by more than one manufacturer.

Combination Products: Drugs consisting of two or more active ingredients.

New Dosage Forms: Of a previously introduced product.

A New Drug Application has been granted by the U.S. Food and Drug Administration for the following new drugs.

CORTROSYN Hormones-Corticoids

Manufacturer: Organon

Nonproprietary Name: Cosyntropin (USAN)

DALMANE Sedative & Hypnotic-Nonbarbiturate

Manufacturer: Roche

Nonproprietary Name: Flurazepam HC1

MIRTHRACIN Cancer Chemotherapy

Manufacturer: Pfizer

Nonproprietary Name: Mirthramycin (USAN)

The following new drugs have been marketed:

NEW SINGLE CHEMICALS

ESKALITH

Manufacturer: Smith Kline & French

LITHANE

Manufacturer: Roerig, Div. Pfizer

LITHONATE

Manufacturer: Rowell

Nonproprietary Name: Lithium carbonate: Ataraxic, Psychostimulant

Indications: Control of manic episodes in manic depressive psychosis.

Contraindications: Significant cardiovascular or renal disease, or evidence of brain damage. Do not administer to children under 12.

Dosage: Acute mania: 600 mg. t.i.d.; long term: 300 mg. t.i.d. Individualize according to serum levels and clinical response.

Supplied: Capsules or tablets, 300 mg.

KETAJECT

Manufacturer: Bristol

KETALAR

Manufacturer: Parke, Davis (Originator)

Nonproprietary Name: Ketamine HC1: Anesthetic-Injectable

Indications: Sole short acting anesthetic agent for diagnostic and surgical procedures. Can be extended for periods of six hours or longer.

Contraindications: History of cerebrovascular accident or hypersensitivity to the drug.

Dosage: Individualized according to patient's requirements.

Supplied: Vials, 20 cc containing 10 mg. base/cc
50 cc containing 10 mg. base/cc
10 cc containing 50 mg. base/cc

NEW INDICATION

Xylocaine Antiarrhythmic

R

Manufacturer: Astra

Nonproprietary Name: Lidocaine (USAN)

Indications: Acute and life-threatening arrhythmias.

Contraindications: Hypersensitivity to local anesthetics of the amide type. Adams-Stokes syndrome and severe degrees of sinoatrial, atrioventricular or intraventricular block.

Dosage: Usual dose: 50-100 mg. intravenously under ECG monitoring administered at approximately 25-50 mg./min.

Supplied: Single dose ampules of 2% solution, 5 and 50 cc. Special package for arrhythmias.

DUPLICATE SINGLE PRODUCTS

CENDEVAX Biological

R

Manufacturer: Recherche et Industrie Therapeutiques, subsidiary of Smith Kline & French

Nonproprietary Name: Rubella virus vaccine, live (Cendehill Strain)

Indications: Immunization against German measles.

Contraindications: Febrile illness, leukemia, lymphoma, generalized malignancy or lowered resistance due to therapy with corticosteroids, alkylating drugs, antimetabolites or radiation. Hypersensitivity to rabbits or neomycin. Do not administer to pregnant women.

Dosage: Injection, s.c. only—0.5 cc.

Supplied: Vials, single dose.

ETHAQUIN Vasodilators-Peripheral

R

Manufacturer: Ascher

Nonproprietary Name: Ethaverine HC1

Indications: Peripheral and cerebral vascular insufficiency associated with arterial spasm; smooth muscle spasmolytic in spastic conditions of the G.I. and G.U. tract.

Contraindications: Presence of complete atrioventricular dissociation.

Dosage: 1 tablet t.i.d.

Supplied: Tablets, 100 mg.

FEMINONE Estrogen

R

Manufacturer: Upjohn

Nonproprietary Name: Ethinyl estradiol

Indications: Hypoestrogenic states.

Contraindications: Known or suspected malignancy of breast or genital organs. Undiagnosed vaginal bleeding. Liver dysfunction or disease. Thrombophlebitis or history of thrombophlebitis or pulmonary embolism. History of cerebrovascular accident.

Dosage: Individualized. ½ to 3 tablets t.i.d.

Supplied: Tablets, 0.05 mg.

OXY-KESSO-TETRA Antibiotic

R

Manufacturer: McKesson, Div. Formost-McKesson

Nonproprietary Name: Oxytetracycline HC1

Indications: Variety of systemic infections, certain infections of the respiratory tract, skin and soft tissues, gastrointestinal and genitourinary tract, due to susceptible organisms.

Contraindications: Hypersensitivity to tetracycline.

Dosage: Adults: 250-500 mg. q.i.d.

Children: As per instructions.

Supplied: Tablets, 250 mg.

SOSOL Sulfonamides

R

Manufacturer: McKesson, Div. Foremost-McKesson

Nonproprietary Name: Sulfisoxazole

(Continued on page 42)



Today's Challenge: Medicine

BY THELMA PEPLOW/SYCAMORE

Keeping abreast of the fast pace in the new and ever-changing field of medicine is a challenge, not only to the physician, but also to the medical assistant. In this age of computers and other new diagnostic and therapeutic methods, the assistant must be able to cope with the changing times. A program of continuing education is the only answer in enabling us to meet our daily work crises.

The Illinois Medical Assistants Association's aim is to educate its members so they can be part of the medical team, thereby improving the relationship between the physician, patient and assistant. Local Medical Assistant Chapters use educational lectures, films and panel discussions to keep the members alert to the many problems with which they may be confronted in their jobs. These programs encompass the varied duties of the medical assistant, such as collections, telephone technique, and office and clinical procedures.

The sole purpose of the Medical Assistants Association is to continue our educa-

tion by reviewing the old and learning the new. Our organization is a non-union, non-profit association, dedicated to better service to the medical profession and to the public.

To have an alert mind, one must keep learning. To have the desire to learn, one should not falter, but be persistent in pursuing the opportunities available. Living in our modern world of acceleration, further education is a necessity. Along with improving our work, we can also learn to understand the needs of our fellowman. This all adds not only to the *education*, but also to the *dedication* of the Medical Assistant.

If your assistant is interested in self improvement, she may contact:

Mrs. Norma Domanic, 1st Vice President
150 Ash Street
New Lenox, Ill. 60451

or

Mrs. Vivian Kraft, 2nd Vice President
R. R. #2
Normal, Ill. 61761

Meeting Memos

July 25-August 15—Polytechnic Institute of Brooklyn

Three week summer course in Research Instrumentation

333 Jay Street, Brooklyn, New York

July 27-August 9—U.S. Department of Health, Education and Welfare

Summer Institute in Suicidology

National Institute of Mental Health, Washington, D.C.

August 12-15—The American Academy of General Practice

Fourth World Conference on General Practice

Palmer House Hotel, Chicago

August 16-21—American Academy of Physical Medicine and Rehabilitation

32nd Annual Assembly

New York Hilton, New York

August 16-21—American Congress of

Rehabilitation Medicine

47th Annual Session

New York Hilton, New York

August 17-21—Western Institute of Drug Problems

Third Annual Summer School

Portland State University, Portland, Oregon

August 19-23—UCLA

Advanced Seminar in Urology

Residential Conference Center, Lake Arrowhead, California

August 20-22—University of Wisconsin

Ninth National Conference on Therapies for Advanced Cancers

University of Wisconsin, Madison

August 23-28—International Diabetes Federation

7th International Congress of Diabetes

Buenos Aires, Argentina

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Popliteal Aneurysm: An Unresolved Problem

By RICHARD C. POWERS, M.D., F.A.C.S., AND ISA SEJDINAJ, M.D., F.A.C.S./ELGIN

In 1948, at the beginning of the era of direct vascular surgery, Linton¹ reported 100% limb survival in a series of 13 popliteal aneurysms treated by preliminary lumbar sympathectomy followed by aneurysmectomy. In a review of the literature, the authors were unable to find a comparably good series reported since that time. However, careful analysis of this frequently quoted report confirms that no aneurysm was thrombosed preoperatively and all patients had at least one intact foot pulse at the time of surgery. As recently as 1966,

Baird² reported continuing failure with the surgical treatment of thrombosed popliteal aneurysm and that "amputation was necessary in half of the thrombosed aneurysms." Janes³ reviewed 100 cases of popliteal aneurysm in 1952, treated and untreated, and concluded that "it is debatable whether there is anything to gain by operating on a popliteal aneurysm which has been completely occluded by a thrombus." This conclusion led to his recommendation that surgical consideration be given to the treatment of popliteal aneurysm prior to development of thrombosis. A decade later, 1962, the same author reported that 50% of thrombosed aneurysms in his series still resulted in amputation. In the same era DeBakey's group⁵ and Julian's group⁶ reviewed similar problems in their series. Hara and Thompson⁷ reported amputation of 10 of 18 limbs after acute occlusion, in 1966, again approximating a 50% limb-loss rate. Our personal series, treated in a community hospital, is small, but further emphasizes that thrombosis of popliteal aneurysm is catastrophic.



Richard C. Powers, M.D. (left), is attending surgeon in vascular surgery, Sherman and St. Joseph Hospitals, Elgin. He is a graduate of the Northwest-

ern University Medical School and served his internship in Evanston Hospital and a residency at Hines V.A. Hospital. **Isa Sejdinaj, M.D.** (right) is a graduate of the University of Graz, Austria, Medical School. He also is attending surgeon in vascular surgery at Sherman and St. Joseph Hospitals.

Case Reports

Case 1. A 58-year-old salesman was referred with a 24 hour history of the exist-

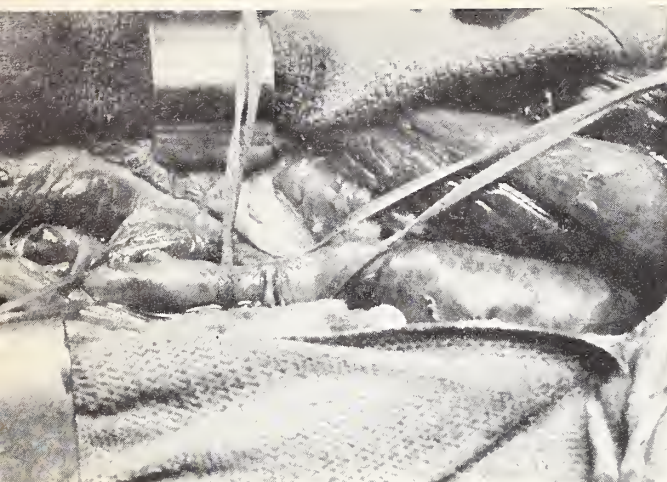


Fig. 1

ence of a cold, painful, pulseless foot. His past history was positive for diabetes mellitus and prior coronary thrombosis. Physical examination was negative except for the above findings, the presence of a tender lump in the right popliteal space, and the presence of a non-tender pulsatile mass in the left popliteal space.

Primary resection of a thrombosed popliteal aneurysm with prosthetic grafting was done 3-4-59. The graft was successful, with return of all peripheral pulses and no residual ischemic compartment.

Two years later the patient expired of recurrent coronary thrombosis; autopsy confirmed a patent graft.

Case 2. A 71-year-old insurance adjuster was referred four days after development unilaterally of a cold, white, painful foot. Past history added nothing, and the physical findings were only as described. Femoral angiography confirmed a thrombosed popliteal aneurysm, with minimal collateral circulation. Emergency resection of the aneurysm, with primary prosthetic grafting, was done 6-22-61. Anterior compartment changes were irreversible, and above-knee amputation followed on 6-25-61. Figure 1 illustrates this long, fusiform aneurysm.

Five years later he was referred again, with a similar history regarding the remaining extremity, in spite of a warning that he should seek prompt care in such an instance. Femoral arteriogram confirmed a thrombosed popliteal aneurysm. This time, lumbar sympathectomy was done, with limb survival. No rest pain resulted; the patient has a useful extremity two years later.

Case 3. On 9-3-63, a 58-year-old factory employee presented with a 30 hour history of a cold, white foot. Emergency femoral angiography confirmed a thrombosed popliteal aneurysm, and this was resected and grafted the same day. Irreversible changes were present and below-knee amputation eventuated. Figure 2 shows a series of berry-like lesions, impossible to feel in the popliteal space.

On 3-2-66, three years later, an almost identical sequence occurred, involving the opposite extremity. The single variation was that the amputation was above-knee. The patient remains a bilateral amputee, aged 62, with limiting coronary artery disease.

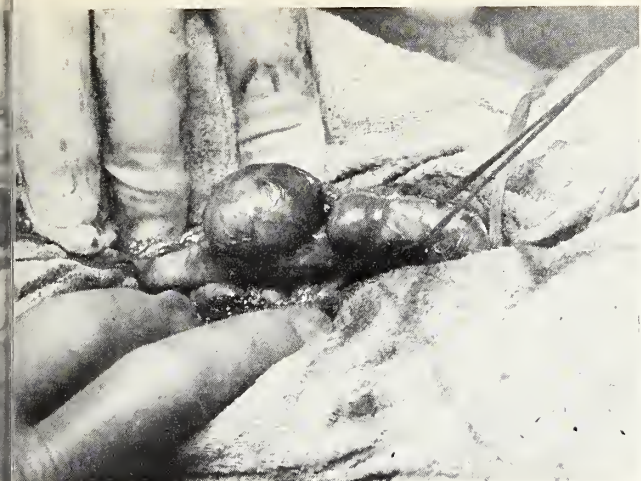
Case 4. A 54-year-old outdoor workman was referred because of a painful, pulsating popliteal mass. Distal pulses were strong. On 11-3-64, the popliteal aneurysm seen in Figure 3 was resected and grafted with a prosthesis. Recovery was uneventful; peripheral pulses remained.

Follow-up examination six months later confirmed an aneurysm in the other leg. Resection was done 8-5-65, and total occlusion of the popliteal artery distally was found. This was due to scarring of the intima, seen at the distal end of the aneurysm in Figure 4. The collateral circulation was carefully preserved, the aneurysm resected, and the proximal end ligated. Extremity loss was expected but did not occur, certainly due to adequate collateral circulation. Presently, the patient has unilateral claudication only, with persistent pulses and no claudication on the grafted side.

Case 5. A 45-year-old musician suddenly developed a cold, waxy foot on 4-29-66. Four hours after onset, angiography, resection of a thrombosed popliteal aneurysm, and prosthetic grafting was done. The limb survived, but the patient was left with a permanent footdrop, preceded by the characteristic evolution of an ischemic anterior compartment. No pulses returned. Two years later, the patient has a persistent footdrop, but continues to play his vibraharp well.

Comment

Our small series of cases represents five patients with eight popliteal aneurysms. Of these, two were apparently patent and were operated upon electively; six were operated



upon at the time of acute thrombosis, on emergency basis. Of these, three limbs survived, but only one of these can be termed successful in the sense of a non-symptomatic limb with intact foot pulses. It appears that our rate of success also is at 50% limb survival.

Since we work in a community hospital, dealing only sporadically with a wide variety of vascular problems, we find that we have had no continuing policy in dealing with popliteal aneurysms. We have dealt with each problem individually. There are certain factors which appear to have altered the clinical outcome of this disease. Some of these are matters over which the physician can exert no influence; some are matters in which the surgeon's approach makes the difference between success and failure.

If the collateral circulation is adequate, the mode of treatment of thrombosed popliteal aneurysm makes no difference. Acute occlusion will be prognostically determinable if the usual signs of ischemia reverse themselves in a short while. Persistent sensory and motor loss almost always signify ultimate amputation. Recovery of motor activity and sensation usually signifies an ultimately useful limb. Limbs three and eight illustrate these factors. However, the extent of collateral circulation is a matter over which the physician exerts no influence.

The physician does bear directly in other areas. Timing is of paramount importance. As in occlusive disease elsewhere, the longer a thrombus is extant, the further the propagation of clot into adjoining collateral vessels and in the distal run-off. The more

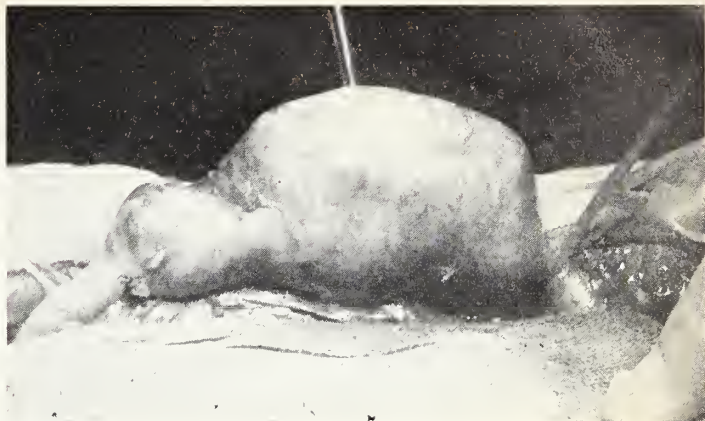


Fig. 3

prompt the excision of the thrombosed structure and re-establishment of arterial thrust, the more certain a surviving limb. Since most patients are under the care of those not oriented to these problems, stubborn and persistent education and re-education remain fundamental to success. The time from thrombosis to grafting must not be more than 3 to 4 hours, if any success is to be obtained. Secondly, arteriography will definitely aid in differentiating acute arteriosclerosis obliterans from thrombosed popliteal aneurysm. The latter simply has to be approached from a straight posterior position; unawareness of the differential results in a need for changing patient position or fighting a very poor exposure to the end of the operation. Limb loss always has medico-legal implications. Although the subtleties of occlusive disease may easily be interpreted by physical examination by the vascular surgeon, they are not so clear to other consultants, attorneys, and jurymen. An arteriogram permits easy explanation



Fig. 4

and leaves a permanent record for future reference.

Aggressiveness is certainly indicated in thrombosed popliteal aneurysm. What to do with patent popliteal aneurysms remains in doubt. Our limited experience with these was gratifying; I wish we had been so fortunate with thrombosed aneurysms. If the patient can understand the problems involved and accept the risk of limb loss, advising elective resection seems reasonable. In almost 30 years, no one has duplicated the results of Linton, which were indeed excellent. The inescapable conclusion seems to be that lumbar sympathectomy contributes considerably to limb survival when there develops a complication of popliteal aneurysm.

Conclusion

The treatment of thrombosed popliteal aneurysm is unsatisfactory. Earlier diagnosis, arteriography, resection and grafting seem the best solution. Lumbar sympathec-

tomy undoubtedly contributes considerably to recovery. Courage on the part of the surgeon and patient alike are necessary to permit excision and grafting of non-symptomatic patent aneurysm. ◀

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Modern Diets Proving Harmful To Teeth

Modern diets are proving harmful to the teeth of Eskimos living in northern Canada, a dental anthropologist at The University of Chicago has reported.

A paper presented by Dr. John T. Mayhall, a post-doctoral trainee at The University of Chicago, describes preliminary studies which indicate that modern food now being consumed by Eskimos in the Northwest Territories of Canada is deteriorating their teeth.

"A study of the teeth of the Eskimos of Igloolik and Hall Beach, Northwest Territories, Canada," Dr. Mayhall said, "reveals that with the introduction of modern foods and tastes, the dental health of the Eskimo inhabitants of these isolated Foxe Basin villages is deteriorating."

"The principal change affecting the dentition during this modernization is a new diet which is extremely different from that which was prevalent only a short time ago and to which some of the Eskimos living in the more isolated circumstances still adhere."

Dr. Mayhall said the tooth decay rate for permanent teeth in Igloolik nearly doubled in those people who had a diet consisting of more than 60% food obtained at the local stores as compared with those

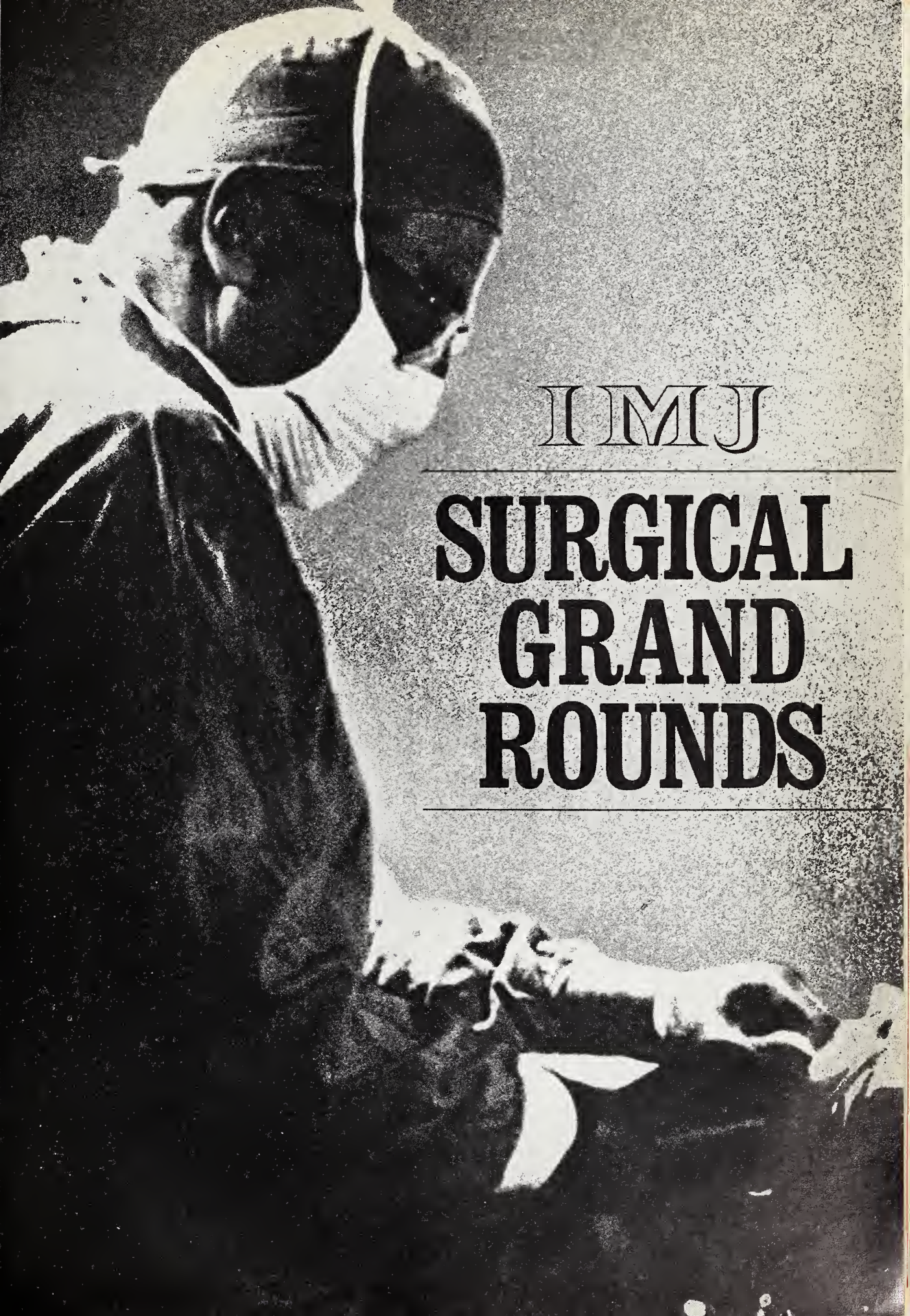
individuals whose diet is principally food obtained from hunting and fishing.

"The latter's main staples," Dr. Mayhall said, "appear to be seal, caribou, fish, and some walrus. Generally, those who had the 'native' diet had less calculus (tartar) on their teeth than did those on the modern diet."

The study was supported by the National Research Council of Canada through the Canadian International Biological Programme, Human Adaptability section. It was undertaken in 1968 to ascertain the effects of a rapidly changing culture upon the dentition of the Eskimos of the Northwest Territories.

"It (the study) was a part of a multi-disciplinary study of Eskimos," Dr. Mayhall said, "and the results presented here are preliminary and based only upon the author's (Dr. Mayhall's) observations without the aid of results from the other investigators. With this material available in the future, more enlightening data will be available."

"At present, a comprehensive dietary survey is under way by Miss Heather Milne of the University of Toronto, which will be available for a more detailed study of the effects of diet."



II MJJ

SURGICAL GRAND ROUNDS

Surgical Grand Rounds are held weekly on Saturday at 8:00 a.m., alternating between the Staff Room, Chicago Wesley Memorial Hospital, and Offield Auditorium, Passavant Memorial Hospital. Patient presentations from these hospitals and from the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds held at Passavant Memorial Hospital on March 22, 1969.

Ureteral Obstruction

EDITED BY JOHN M. BEAL, M.D.

CASE REPORT:

Dr. Gerald Halpern: A 76-year-old male was admitted to Passavant Memorial Hospital for the first time on Feb. 26, 1969, for the evaluation of recurring hematuria. The patient was well until 1960, when, after an episode of hematuria, he was discovered to have a bladder tumor. Transurethral removal of the tumor was performed. The patient was well for five years. However, in 1965 he had an episode of gross hematuria and again transurethral resection of the bladder tumor was required. From 1965 to 1968, the patient was subjected to cystoscopy yearly. On each occasion, a bladder tumor was found and resected endoscopically. In July, 1968, an intravenous urogram showed non-function of the right kidney. One month prior to admission, he again developed total gross hematuria with dysuria and frequency and hourly nocturia associated with a dribbling stream and hesitancy.

Physical examination at the time of admission: The patient was a pale, elderly white male. Blood pressure 160/70, pulse

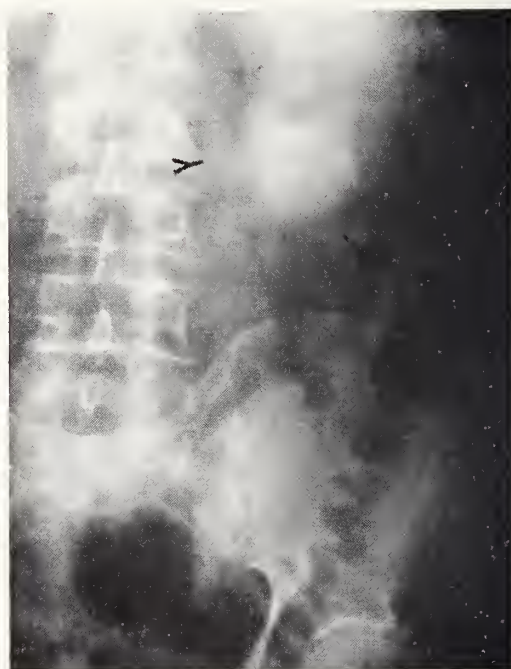


Fig. 1. Intravenous pyelogram, four hours after injection, demonstrated hydronephrotic left renal pelvis.

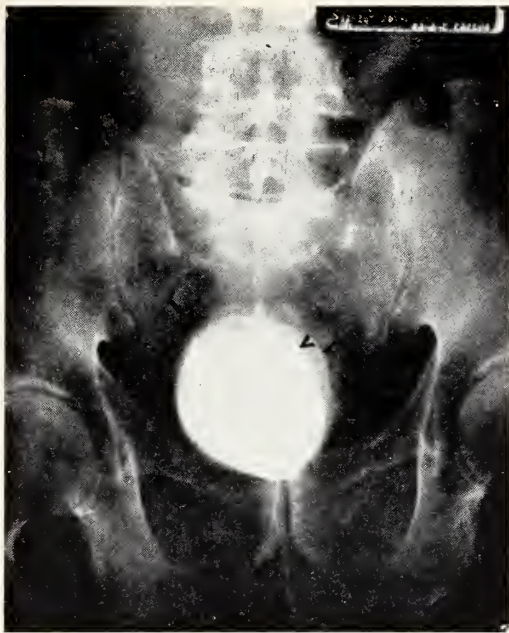


Fig. 2. Triple exposure film of the bladder showed good mobility of the left bladder wall during emptying. The large arrow indicates area of fixation of right bladder wall.

72, temperature normal. Examination was within normal limits, except for the prostate which was moderately enlarged but smooth and symmetrical. Enlargement of the spleen, kidneys, or liver was not detected. Laboratory data showed a hemoglobin of 7.1 Gm., hematocrit 22%. His white count was 6,400, and his sedimentation rate was 69. BUN—62, uric acid—5.1, creatinine—4.7 mg./%. Urine was sterile when cultured.

Dr. Michael Murphy: A double dose intravenous pyelogram was done in February and it again showed non-visualization of the right side. At 15-minutes there was faint visualization on the left. A follow-up film taken four hours after injection showed definite excretion of contrast material into a hydronephrotic left renal pelvis (Fig. 1). Renogram confirmed the findings of the I.V.P. It showed poor function bilaterally; there was uptake of radioactivity on the left, but none on the right. Cystogram failed to show intrinsic defects in the bladder. After this study was completed, the bladder was distended with contrast material, and a triple exposure film was taken as the bladder emptied (Fig. 2). I believe you can see the three outlines of the bladder wall on the left, corresponding to the

three exposures. However, the bladder wall on the right side is relatively fixed. Although fibrous adhesions from previous surgery and radiation could cause this, we thought that it was more probably caused by recurrent bladder tumor.

Dr. Halpern: At this time, the clinical impression was recurrent bladder tumor with bilateral ureteral obstruction causing uremia. After transfusions of whole blood, cystoscopy was performed on March 4. A bladder tumor could not be visualized endoscopically; however, two suspicious areas at the bladder neck were biopsied, which did not demonstrate malignancy. He did have a stricture at the ureterovesical junction and also a mild bladder neck contraction. It was decided that the patient would benefit from diversion of his urinary stream, and therefore, two days following cystoscopy, a left cutaneous ureterostomy was performed. The patient has had a satisfactory course since operation.

Dr. Joseph Sherrick: In spite of the fact that this patient had been treated for carcinoma of the bladder since 1960, we were unable to find any tumor in the multiple biopsies of the bladder taken by Dr. Halpern. In one biopsy (Fig. 3), there was a

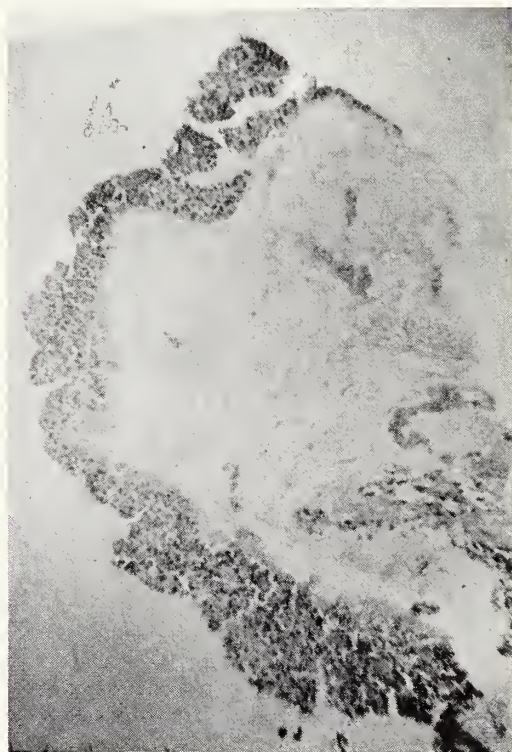


Fig. 3. Biopsy of bladder wall was interpreted as demonstrating edema and inflammation.

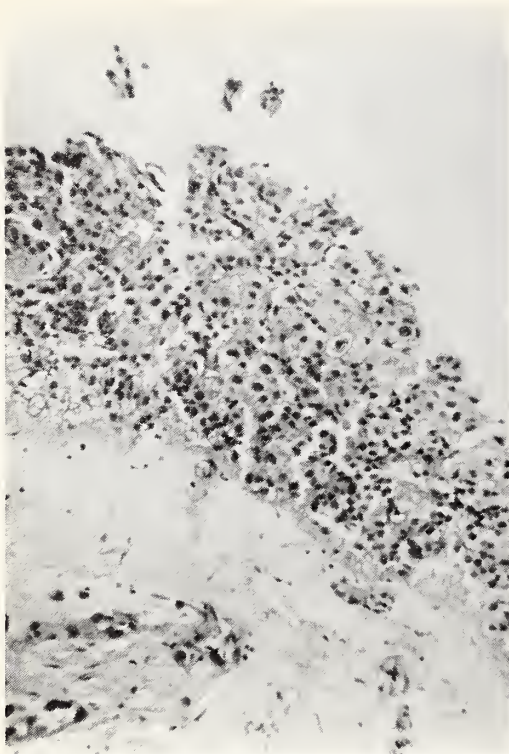


Fig. 4. The bladder mucosa was distorted and showed atypical hyperplasia, probably related to previous irradiation.

structure composed of distended lymphatics and edematous connective tissue which is an inflammatory polyp. The epithelium covering all the biopsies seemed thicker than in the normal urinary bladder. On close examination, one can see that there is some loss of stratification of the epithelium, but the transitional pattern is still preserved. Some of the epithelial cells are pleomorphic, but there is no mitotic activity (Fig. 4). We regard this as being atypical hyperplasia of the bladder epithelium and not cancer. This peculiar dysplastic change may possibly be related to radiation or to unknown factors. It would be of great interest to have an opportunity to review the bladder biopsies taken from this patient at other hospitals since 1960.

Dr. John Grayhack: This patient actually demonstrates the value of establishing a definite diagnosis. He presented with a history which was typical for carcinoma of the bladder. He had had history of transitional cell carcinoma of the bladder with repeated recurrences documented over a nine year period. Hematuria and bladder symptoms were persistent. The patient then developed ureteral obstruction and was actually se-

verely azotemic and anemic when he was first seen by us. Our initial impression of this 76-year-old man was that he had both ureters obstructed by his carcinoma, one totally probably and the other partially for only eight months, and that there was little reason to be too vigorous in pursuit of either a diagnostic or a therapeutic regimen. On reflection, we recognized that our presumptive diagnosis should be verified. Surprisingly, we could not document the presence of persistent malignancy despite multiple biopsies. We were unable to identify either ureteral orifice at cystoscopic examination. These findings suggested that the patient had a fibrotic obstruction of both ureters following transurethral resection, a phenomenon which is recognized but rare. Under these circumstances, we elected to divert the patient's urinary stream. Several types of permanent diversion are available in a patient who requires supravescical diversion (Fig. 5). Actually, nephrostomy tube drainage is a satisfactory form of diversion. It is usually used for temporary rather than long-term diversion. The various types of cutaneous ureterostomy are also shown. Probably the most satisfactory is the high cutaneous ureterostomy. This procedure utilizes the well vascularized upper third of the ureter. Ureteral length is adequate to permit ureteral cutaneous anastomosis without tension. Fitting an adequate appliance to the ureterostomy site is difficult. The classical cutaneous ureterostomy, utilizing the middle third of the ureter, produces a notoriously bad result unless the ureter is dilated. This is probably due to two factors: 1) the blood supply to this segment of ureter is poor. The lower third of the ureter receives the major portion of its blood supply from below. In this procedure, you divide the ureter at about the site of its poorest blood supply. 2) When you bring the ureter retroperitoneally, you rarely have enough length to reach the skin without tension. These factors result in a high incidence of stricture of the stoma and slough of the distal ureter, complications that have caused this particular type of diversion to fall into disrepute. The single stoma transperitoneal ureterostomy has been utilized primarily in youngsters but is gaining popularity in other instances since we have learned from the use of the ileoconduit that

we can cross the peritoneal cavity with a tubular structure and still not get into too much trouble with intestinal obstruction. The classical and high ileal conduits are probably the most satisfactory types of supravescical diversion from the standpoint of long term survival. A mortality rate of about 3% is associated with the ileal conduit for nonmalignant disease. Ureterosigmoidostomy, shown at the bottom of Figure 5, cannot be utilized with safety in a patient who has a large, dilated ureter. It does have a place as a palliative procedure and actually has a place in some elderly patients in whom attempted curative surgery is carried out. It has a disadvantage in that there is a high incidence of pyelonephritis following it as well as the peculiar hyperchloremic acidosis which is associated with a large percentage of patients who have this type of diversion. In this man, we elected to do a cutaneous ureterostomy on the left side only since he was a poor risk patient. We knew that the right side was not functioning, at least by intravenous pyelography, for some ten months. The ureter which was obstructed at the ureterovesical junction was very thick-walled, a finding which suggests an increased blood supply to the ureter. This is the type of ureter which is ideal for a cutaneous ureterostomy. We brought the ureter in a transperitoneal course so that it could approach the skin directly and be under less tension. In the postoperative period, the patient had an interesting phenomenon which is often seen in patients with marked renal failure. His blood urea nitrogen went from 60 to about 130 mg.%. His creatinine rose but not to the same extent as his BUN. The question of dialysing him was raised just about the time he began a diuresis. His BUN now is about 30. The phenomenon of apparent increasing renal failure in the postoperative period could well be related to an increasing obstruction from the non-intubated cutaneous ureterostomy and the extra load placed on the kidney by the tissue breakdown associated with the surgical procedure. One thing that you must remember in a patient who has renal failure of this nature, who requires an operative procedure, is that you have to be careful about fluid replacement and particularly about potassium administration or accumulation. Since hemolysis may increase the

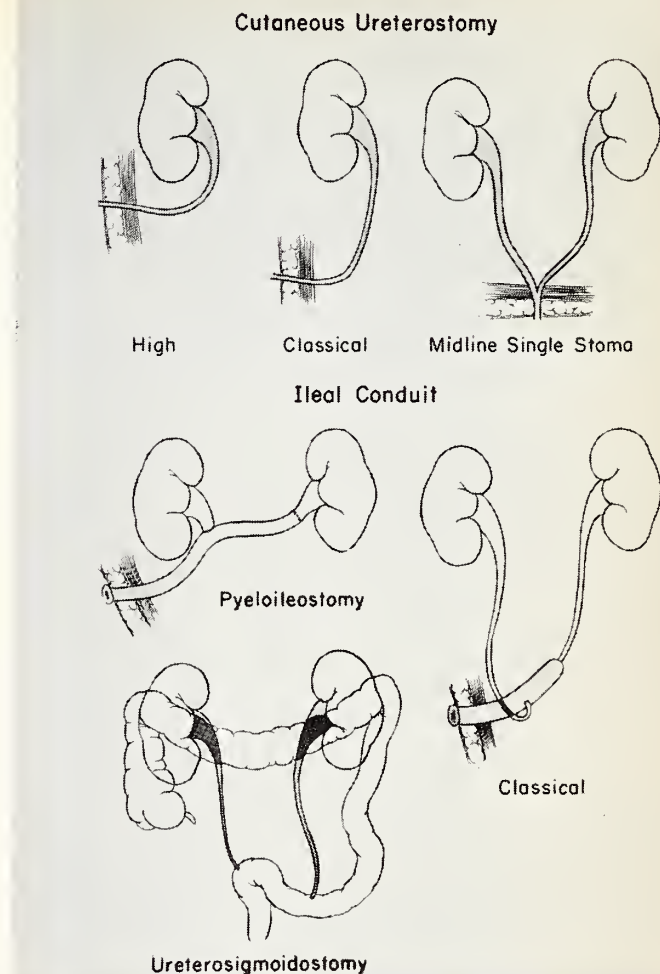


Fig. 5. (labeled) Methods of Permanent Urinary Diversion).

serum potassium of blood significantly, prior to administering large quantities of blood to these patients you ought to make an effort to get fresh blood and to arrange to monitor serum potassium and ECG changes closely.

Dr. John Beal: Was re-implantation of the ureter into the bladder considered?

Dr. Grayhack: This was a consideration. Despite the negative biopsies, we weren't entirely sure that the patient didn't have bladder cancer. We biopsied the lower end of the ureter and perivesical area; these biopsies showed fibrosis, but no evidence of carcinoma. This ureter had a diameter of about 1.5 cm., and probably two-thirds of that was the wall. To attempt to reimplant that in a man who already has renal failure and in whom any minor insult might be a terminal one would be very hazardous. If you knew the status of the bladder with certainty and if you had a ureter which you could implant, neither of which was true,

reimplantation would deserve primary consideration. His right kidney is functionless as far as we can tell. He passes no urine from his bladder. He undoubtedly has a hydronephrotic sac on the right side which we do not intend to molest.

Dr. Douglas Dahl: Were you certain that the right kidney was not making urine?

Dr. Grayhack: No, I was not. We were faced with the possibility of doing a bilateral cutaneous ureterostomy for a non-functioning kidney which would leave us with an open infected draining stump and which would require prolongation of an operative procedure in a seriously ill old man. We considered doing a transuretero-ureterostomy, joining the right ureter to the left and bringing the left to the skin. We didn't feel that it was worth while jeopardizing the one good ureter for one that we thought was no good. We felt that if urine production by the right kidney caused him symptoms without contributing significant function, and his left side re-

covered function, the ideal procedure would be to do a right nephrectomy in this man later. We were concerned about the status of the right kidney, but our assumptions seem well founded.

Dr. Stuart Poticha: When you bring the ureter out to the skin of the abdomen, do you attempt to fix it to the lateral peritoneal wall?

Dr. Grayhack: The transperitoneal ureterostomy is not done commonly. We bring the left ureter medial to the colon, usually at the level of the sigmoid. A flap of posterior peritoneum with the mesosigmoid is utilized to cover the ureter in part. A major segment of the ureter is still retroperitoneal. We've not anchored the sigmoid to the ureter, although we've wondered about it. The ureteral blood supply is so tenuous, that we really hesitate to place sutures in the mid-ureter. We put one suture in the periureteral tissue as the ureter enters the parietal peritoneum and the posterior fascia; except for this, we rely upon skin sutures to secure it. ◀

New Pharmaceutical Specialties

(Continued from page 26)

Indications: Variety of infections susceptible to sulfonamide therapy.

Contraindications: Hypersensitivity to sulfonamides. Infants less than 2 months of age. Pregnancy at term and during nursing.

Dosage: Varies with age and indication.

Supplied: Tablets, 0.5 gm.

STEPS Vasodilator R

Manufacturer: Dow

Nonproprietary Name: Pentaerythritol tetranitrate

Indications: Relief and prophylactic treatment of angina pectoris.

Contraindications: Idiosyncrasy to drug.

Dosage: 1 capsule every 12 hrs. on an empty stomach.

Supplied: Timed disintegration capsules, 30, 50 and 80 mg.

TETANUS IMMUNE

GLLOBULIN (Human) Biological R

Manufacturer: Wyeth

Nonproprietary Name: Human gamma globulin 16.5 (± 1.5) % sol.

Indications: Immunization against tetanus

Contraindications: Do not give intravenously.

Dosage: Adults: i.m., 250 units.

Children: i.m., 4.0 units/kg.

Supplied: Solution (Tubex)

TUBERCULIN Diagnostic R

Manufacturer: Connaught Medical Research Laboratories, Canada

Distributor: Panray Div., Ormont

Nonproprietary Name: Stabilized tuberculin, purified protein derivative (Mantoux)

Indications: Intracutaneous tuberculin testing

Contraindications: None mentioned.

Dosage: Initial intracutaneous tuberculin test, 5 T.U.

Supplied: Vials, 1-5 cc

COMBINATION PRODUCTS

FERROBID Hematinic R

Manufacturer: Meyer

Composition: Ferrous fumarate 225 mg.
Copper sulfate 8 mg.
Ascorbic acid 100 mg.

Indications: Prevention and treatment of iron deficiency anemias.

Contraindications: None mentioned.

Dosage: Adults: One capsule twice daily. More severe anemias: One capsule t.i.d.

Children: As directed.

Supplied: Duracap timed action capsules.

DEMULEN Oral Contraceptive R

Manufacturer: Searle

Composition: Ethynodiol diacetate 1 mg.
Ethinyl estradiol 50 mcg.

Indications: Oral contraception.

Contraindications: Thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions. Markedly impaired liver function. Known or suspected carcinoma of the breast or estrogen-dependent neoplasia. Undiagnosed abnormal genital bleeding.

Dosage: One tablet daily in 20 day cycles.

Supplied: Tablets.

MTC Oil Nutrient o-t-c

Manufacturer: Mead Johnson

Composition: Lipid fraction of coconut oil consisting primarily of triglycerides of the C₈ and C₁₀ saturated fatty acids.

Indications: Restriction of dietary fat intake to medium chain triglycerides.

Contraindications: None mentioned.

Dosage: 3-4 tbs. daily mixed with food.

Supplied: Oil



public
affairs
library
reviews

Do It! By Jerry Rubin, Simon and Schuster, New York, N.Y. \$2.45

In the wake of the violence that swept across the campuses and the country in the past few weeks, we have become intrigued with a depraved little volume published by Simon and Schuster called *Do It!* Written by Jerry Rubin, one of the "Chicago 7" gang recently convicted of crossing state lines to provoke a riot, the book—aside from being saturated with obscene language—spells out some of the thinking of America's youthful revolutionaries.

Rubin, indeed, is quite frank. He says the idols of the New Left are Che Guevara, Fidel Castro, and the Viet Cong—and he appears to relish the idea of bringing guerilla warfare to the United States.

He approves of virtually any tactic to bring down the Establishment, including sabotage, treason and the killing of cops. "We've combined youth, music, sex, drugs and rebellion with treason—and that's a combination hard to beat," he says at one point.

At still another: "When in doubt, burn. Fire is the revolutionary's god. Burn the flag. Burn churches. Burn, burn, burn." Jerry is also for stealing: "All money is theft," he says. "To steal from the rich,"

he continues, "is a sacred and religious act. To take what you need is an act of self-love, self liberation. While looting, a man to his own self is true."

The well-known Yippie leader acknowledges that the demands of demonstrators are deliberately unreasonable. The basic bargaining tactic of the revolutionary, he says, is: "Give us an inch—and we'll take a mile. Satisfy our demands and we got 12 more. The more demands you satisfy, the more we got. . . . Demonstrators are never reasonable. We always put our demands forward in such an obnoxious manner that the power structure can never satisfy us and remain the power structure. Then, we scream, righteously angry, when our demands are not met."

Jerry Rubin has written *The Communist Manifesto* of our era. *Do It!* is a Declaration of War between the generations—calling on kids to leave their homes, burn down their schools and create a new society upon the ashes of the old. . . .

For those of you who appreciate the form of government we now have, you might want to read about those who would change our system. You may not enjoy reading *Do It!* but it should be an eye opener.

The Pill

Science writers also appear to be moving toward more sophisticated levels of analytical reporting of science's economics, politics and priorities. In his book, *THE PILL*, Morton Mintz of the *Washington Post* chronicles just how the degree of danger seen in birth control pills depends a great deal on the expert's viewpoints. Medical scientists fixed upon the problems of population explosion rate the risks as very small, less dangerous than pregnancy. Researchers and doctors focused on individual patients, generally in the upper and middle classes, considered the risks of pregnancy less serious than risking complications associated with hormone contraception. Judith Randal, writing in the *Washington Star*, criticizes the medical men for forgetting—or ignoring—the desirability of warning patients that all powerful drugs involve risks. (Warren Burkett, "There's More Going On in Science Than Some Would Tell," *The Quill* [May] 1970, pages 16-19.)

Failure of thymectomy

In a six-year old child

With myasthenia gravis

BY CHANG HWAN KIM, M.D., BENNETT R. SHERMAN, M.D.,
AND MEYER A. PERLSTEIN, M.D./CHICAGO

Thymectomy for myasthenia gravis was first reported in 1939, by Blalock.¹ Most reports deal with thymectomy in adults; only a few in children.^{6,8,14,21,25}

Thymectomy has been performed mainly when a thymoma is present and particularly in female patients between 20 and 35 years of age. Since, with advanced surgical technics, thymectomy can be carried out with minimum risk, the procedure may be indicated when there is poor response to medical regimen.

The case being reported here documents another instance of myasthenia gravis in a 6-year old child and the failure of thymectomy to have therapeutic benefit.

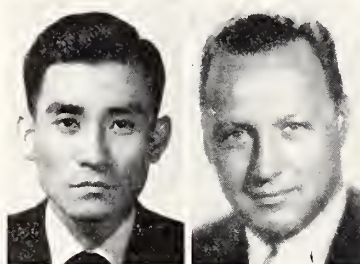
Case Report

H. C., an 18-month-old Negro male (6 years old at the time of surgery) was admitted to the Children's Division of Cook County Hospital on Nov. 11, 1962, for evaluation of complaint that for two weeks he was unable to open his right eye. The patient appeared normal in the morning, but later in the day his right lid began to droop, and by evening was almost completely closed. He was first born to a 20-year old mother after an uncomplicated pregnancy. Birthweight was eight pounds. There was no history of familial or hereditary illnesses.

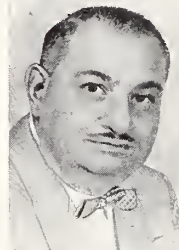
On physical examination, ptosis of the right lid was the only abnormal finding. At a previous admission for respiratory infection two months earlier, no eye abnormality had been noted. There was no dys-

phagia. Five milligrams of Tensilon was injected intravenously following which the child was able to move his lid in normal fashion. A diagnosis of myasthenia gravis was made.

Treatment was begun with prostigmin, 7.5 mg. gradually increased to 22.5 mg. t.i.d., and ephedrine, 8 mg. each morning.



Chang Hwan Kim, M.D. (far left), is a pediatric neurology consultant, Reed - Chicago State Hospital. He is a graduate of the Yeu Sei Univ. College of



Medicine, Seoul, Korea and served his internship in Albany, N.Y., and a residency at Jefferson Medical College Hospital, Philadelphia. In addition he has done fellowship work in pediatric neurology under the United Cerebral Palsy Foundation at Cook County Hospital. Bennett R. Sherman, M.D., (left)

is a practicing pediatrician and an associate in pediatrics at Cook County, Evanston Hospital and Northwestern Univ. Medical School. He received his M.D. from the Univ. of Illinois College of Medicine and served his internship and residency at Michael Reese. M. A. Perlstein, M.D. (below left) was professor of pediatrics, Northwestern Medical School and head of Pediatric Neurology at Cook County Hospital. A graduate of Rush Medical School, Dr. Perlstein served his internship and residency at Cook County. Dr. Perlstein died recently after moving to California.

The ptosis however, did not improve. In fact, the patient developed ptosis of the left lid also. Prostigmin was discontinued and the patient was started on Mestinon, 120 mg. daily, gradually increasing to 60 mg. q.i.d., before a favorable response was obtained. The child was discharged on Dec. 22, 1962, six weeks after admission.

Continuing Treatment

Following this first admission there have been 13 additional admissions to the hospital in five years. Many of these were for respiratory distress, with asthma generally associated with a bronchiolitis which responded to epinephrine, aminophylline and intravenous fluids.

On admission on January 20, 1966, he was also given corticosteroids. At this time, a cholinergic reaction was considered and Mestinon was withdrawn. Ptosis and asthmatic symptoms persisted. The patient became refractory to Mestinon and the ptosis persisted in spite of giving sufficient drug to cause abdominal cramps. The patient was then tried on Mytelase, 5 mg. t.i.d. increasing to 10 mg., t.i.d. This also was discontinued after a week when the patient failed to respond.

An electromyogram was normal. The patient was discharged without medication and was doing well other than for ptosis until he was re-admitted on Dec. 1, 1967, at the age of 6 years, in acute respiratory distress with asthmatic symptoms. His acute symptoms were alleviated with epinephrine, aminophylline, Tedral and supportive measures. Examination at this time showed total paralysis of all extra-ocular muscles.

Laboratory work including hemogram, urinalysis and blood chemistry was normal. Chest X-ray showed no thymic enlargement. Because of his extreme refractiveness to medical treatment, thymectomy was done on Dec. 15, 1967. The thymus was enlarged with extension of its lateral lobes up into the neck. It weighed 35 grams upon removal (normal for this age is 24 grams). Histologically the specimen was normal. His post-operative course was uneventful. There was no immediate or late post-operative improvement in his ptosis or ocular muscle palsy.

The patient was followed in out-patient clinic for six months. There was no improvement. Mestinon now caused cholin-

ergic reactions in previously tolerated doses, in spite of the use of atropine sulfate. No drugs are being given at the present time and the patient remains as before surgery—no better, no worse. There is still a bilateral ptosis and ophthalmoplegia.

Discussion

Myasthenia gravis is rare in infants and children.^{2,4,5,9,10,18,19,26} The disease seems more prevalent in Negroes in our own and in Dr. Ford's clinic and in the age range of 18 months to 10 years.⁴

The incidence in females is 4.5 times higher than males during the first decade.²³ Those reported in the neonatal period are usually a transient illness passively transferred from an affected mother.^{17,24} The prognosis in children is generally poor despite the use of a large variety of pharmacologic agents as well as X-rays and thymectomy. Although muscle weakness and dysphagia are frequently benefitted by drug therapy, ptosis and ophthalmoplegia are the most refractory symptoms. The period of adolescence is a most difficult barrier.

Thymectomy has been done with therapeutic benefit mainly in adults with myasthenia gravis whose response to medical regimen had been unsatisfactory.

In 1950, Ritter and Epstein²¹ reported a 9-year-old child who died about 4 months after thymectomy without any post-operative benefit. Thymectomy was of no avail in the case of a 14-year-old girl, reported by Goya.⁶ The youngest patient with myasthenia gravis in whom thymectomy had a favorable effect was a 25-month-old girl reported by Sutin and Hewiston.²⁵

The most encouraging report of benefit from thymectomy in children with myasthenia gravis is that of Keynes¹² who cured 14 of 21 children (2½ to 16 years) so that they no longer needed drugs. In reviewing the study of 78 patients subjected to thymectomy in the report of Schwab and Leland,²² more benefit from surgery was obtained in female than male patients and in those 21 to 30 years of age. The remission rate after 31 years of age was very low, particularly in males.

Osserman and Genkins²⁰ hold that age rather than sex is the major factor in the selection of patients for thymectomy; relatively young patients with recent onset of symptoms do best. Simpson's²³ study, on

the other hand, showed little evidence that better operative results are obtained in the younger and female group.

The child presented in this report had ocular myasthenia which started with ptosis of the right lid and progressed to involve the left lid and then all of his extraocular muscles. The incidence of ocular myasthenia varies from 4.5% to 29.7%.²³

Although patients with myasthenia gravis are usually referred for surgery when thymoma is present regardless of the severity of the disease,^{7,11,12,22,23} the result was poor in the reports of Keynes,^{11,12} Schwab and Leland²² and Simpson.²³ In the report of Kreel, Osserman, Genkins and Kark,¹⁶ the patients with thymic hyperplasia were more benefitted than the patients with thymoma.

The indications for thymectomy in myasthenia gravis given by Kreel, et al¹⁶ were: 1) *Thymoma*, all patients; 2) *Benign hyperplasia*, under 40 years with onset less than five years previously and refractory to medication. According to Kreel, et al,¹⁵ 14 or 15 thymectomized patients had a dramatic, though sometimes transitory, remission of their myasthenic symptoms immediately after recovery from anesthesia. Our patient had no such remission.

The concomitant presence of bronchial asthma, non-cholinergic, with recurrent acute attacks in our case may be an important part in the refractory response to medical and surgical treatment. In the report of Kreel et al, the only mortality among the 15 patients operated was an 18-year-old girl with myasthenia and bronchial asthma.

In adults, the younger the patient, the shorter the history, the better the response to thymectomy.^{3,8,13} However, to assess the effect of thymectomy as a treatment of myasthenia gravis in infants and children, there should be a critical review of a large number of cases. The rarity of this disease in children puts this task far ahead.

Summary

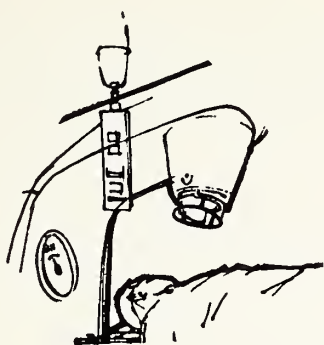
A case of myasthenia gravis in a 6-year-old child is reported with an unsatisfactory response to medical and surgical treatment. Two elements are considered as the possible contributing cause of failure to respond to thymectomy in spite of having had a large thymus:

1. Concomitant presence of non-cholinergic bronchial asthma;
2. Presence of ocular myasthenia. ◀

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Medical Progress



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Contemporary Practices in Ophthalmology

"Our sight is the most perfect and most delightful of all our senses. It fills the mind with the largest variety of ideas, converses with its objects at the greatest distance, and continues the longest in action without being tired or satiated with its proper enjoyments."

—Joseph Addison (*The Spectator*) 1812

BY JOHN G. BELLOWES, M.D., PH.D./CHICAGO

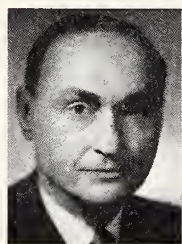
Sight is man's most precious and useful means of sense perception; yet it is a cruel irony that thousands of Americans needlessly become blind every year. Sight enables man to probe all dimensions and distances, whereas the other senses that enhance the human personality are effective only through actual contact or close proximity.

Vision, in its narrowest and broadest sense, permits man to explore both the near world and to reach into the distant corners of the universe. Almost 85%

of our knowledge of the outside world is gained through visual perception. Man utilizes this visually acquired information to ascertain facts, to form opinions, and to make judgments.

The knowledge explosion that continues apace in all of medicine is perhaps nowhere more evident and dramatic than in ophthalmology. Even the ophthalmologist with an extensive practice is hard-pressed to keep abreast of the continuing advances in this dynamic field. It must be conceded that the physician has a truly difficult problem because he is concerned with keeping current in many fields. However, some knowledge of the latest work in ophthalmology will be most valuable because the physician is frequently the first to be consulted and many eye conditions require early and vigorous treatment.*

The well informed physician should be able to administer proper treatment, counsel and advice for some ocular problems



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He took his internship and residency at Cook County Hospital and is the author of two books in his field as well as more than 80 papers. Dr. Bellows is a founder of the Society of Cryosurgery and is editor of *Annals of Ophthalmology*.

*Writing in the June, 1970 *Annals of Ophthalmology*, Dr. Morris Fishbein cites a pertinent observation by Dr. Francis Head Adler: "Of all the specialties, ophthalmology is nearest to general practice."

and diseases and to recognize his limitations in managing other eye diseases requiring specialist care. Although it would be impossible to describe in one paper all of the important ophthalmologic advances of recent years, the information that is of particular significance and interest to the internist and general physician will be described.

How We See

No longer tenable is the old belief that sight is the result of an object forming an image on the retina which is transmitted to the visual cortex of the brain to produce a "picture." The role of the brain in the visual process is now known to be far more complex and to be more closely analogous to data processing than to the formation of an actual image.¹

The visual image of an object *per se* goes no further than the retina. The visual cortex of the brain receives nerve impulses first generated in the retina; these are decoded in the brain. The pathway for the visual impulses which begin in the photoreceptors of the retina is along the optic nerve. At the chiasma the optic nerve separates into two halves, with the nasal halves crossing over. Thus the fibers, from the lateral half of one eye and the nasal half of the other eye, unite to form the optic tract which is the pathway that leads the stimuli to the lateral geniculate body. Here the receptive ganglion cells receive the impulses from the homologous halves of the retinas. At this junction, chemical substances are released producing impulses which are transmitted by means of the optic radiations to the visual cortex of the brain. These impulses travel at the rate of about 100 meters per second. The visual cells of the brain which are in the calcarine fissure of the cerebral cortex receive these impulses and immediately proceed with decoding the stimuli. In a method resembling data processing the visual cells yield "bits" of data which are conceptualized by the individual in the form of the image he sees.

Not only visual information arises from the activity of the stimulated cerebral visual cells but also responses to suit the occasion are generated. In lower animals the most important responses center around survival, and the reactions are instinctive. Sight plays a larger role in man than in animals because man has developed binocular vision

with depth perception. These capabilities enable man to judge distance. "Man sees a landscape, but the lion smells it," is an old adage. Conversely man's ability to smell and to pinpoint the source of an odor is far inferior to that of many animals. The superiority of man over lower animals depends in a large measure on his ability to see better and also to build up experiences. As a result of his superior sight, man enjoys the greater powers of recognition, memory, habit, logic, evaluation, and judgment. The stereoscopic qualities of his vision and the ability to converge, enabling man to develop manual and other skills, have resulted in the growth of his brain and his power to think.

Bacterial Infections of the Eye

Until about 1945, infections of the eye by *Neisseria gonorrhoeae*, *Corynebacteria diphtheriae* and *Diplococcus pneumoniae* were common causes of blindness. Since that time loss of vision from these organisms has been virtually eliminated.

Now the staphylococcus group of organisms, especially those which produce penicillinase and those which develop resistance to the common antimicrobial agents, are of growing concern to the ophthalmologists. Drug resistance plays a greater role in the infections caused by staphylococci than in those caused by any other organism.

Resistant staphylococci are frequent inhabitants in hospitals, especially among patients, attendants, nurses, residents, and the attending staffs of physicians. The resistant patterns vary from hospital to hospital depending upon the most common antibacterial agents used in the particular institution. The patient may actually be infected in the hospital; this has been demonstrated in patients whose conjunctiva were free of pathogenic organisms on entering the hospital but whose cultures two or three days later showed them to be harboring staphylococci in their conjunctivas. It is conceivable that if these patients undergo intraocular surgery the ubiquitous staphylococci may invade the wound and cause an intraocular infection.

In many instances it is impossible to identify the infectious agent causing the intraocular infection. When infection occurs, the eye surgeon employs an antimicrobial agent that is *not* commonly used at the

hospital. He chooses an antibiotic that has a broad spectral base to attack gram negative organisms that may also be present. For these reasons, eye surgeons presently substitute for penicillin one of the following agents: methicillin, erythromycin, colistin, gentamycin, sodium cephalothin and cephaloridine.

External Viral Infections of the Eye

In this country the most common exogenous viral infections of the eye are herpesvirus keratitis and infections caused by the adenovirus types 3, 7, and 8. The adenovirus infections of the eye are self-limiting and cause no visual impairment.

Herpesvirus infection has been known medically for centuries. The word herpes is of Greek origin meaning "creep." Nearly 100% of the population harbor the virus. The tendency for latency and repetitive eruptions are well known to the physicians. When herpesvirus infection involves the cornea (herpesvirus keratitis) it may cause serious impairment of sight. This viral infection of the cornea is now the leading cause of corneal scarring, having replaced trauma and bacterial infections that were formerly the chief causes of impaired vision from corneal scarring. An acute herpetic eruption of the cornea may be precipitated by exposure to sunlight, wind, or the application of eye drops containing steroids. The high fevers accompanying malaria may also precipitate a herpesvirus eruption. This type of infection is of importance to the military ophthalmologist in Vietnam as well as to civilian physicians treating malarial infected American veterans who may have recurrent high fevers. The tendency of herpesvirus keratitis to recur and to become chronic frequently leads to the involvement of the corneal stroma with permanent corneal scarring.

Fortunately, in recent years the use of IDU (5-iodo-2' deoxyuridine) and the newer antiviral agents have been a major contribution in combating herpesvirus keratitis. Another new advance in the treatment of this disease is the application of low temperature by means of a cryoprobe applied to the herpes lesion of the cornea. Recovery rates following cryotherapy have been reported to be over 95%, in contrast to the 50-70% recovery rate with antiviral agents.² Even more recently, the use of in-

terferon inducers offer great hope for preventing visual loss from this disease.

Transfer of Maternal Viral Infections to the Fetus

Viral infections with ocular involvement can be transferred from the mother to the embryo or fetus and result in very serious problems. Rubella, rubeola, and cytomegalic inclusion diseases are of greatest importance in this regard.

An infection of the embryo in its early days of development will cause more serious malformations and even a miscarriage. It follows that infections later in pregnancy, when most of the organs have already been formed, will produce less serious effects. A miscarriage or a stillbirth may occur even when the mother has fully recovered. Occasionally the mother may have a very slight infection which appears insignificant, or she may not even be aware that she has had an infection, but at birth the fetus may show serious eye malformations as well as marked defects of the heart and other parts of the body.

Early recognition of the infection in the mother enables the physician to alert the parents to the possibility of fetal malformations and even its death. Some physicians employ gamma globulin although its value is questionable. The real hope for the elimination of the rubella virus as a factor in producing ocular defects lies in immunization programs with vaccines.

PLT Group of Atypical Viruses

In the United States eye infections by the psittacosis-lymphogranuloma-trachoma group of atypical viruses have become rare. However, the PLT group is still a major cause of blindness in underdeveloped countries. Even in these regions, trachoma, the most important disease of the group, could be eliminated if those governments made concerted efforts to treat patients with local and systemic sulfonamides, tetracyclines, streptomycin, rifampin and other antibiotic agents.

Glaucoma

It is estimated that two million persons in the United States over the age of 35 are threatened with incurable blindness from glaucoma. If untreated, glaucoma destroys the optic nerve. More than half

of the potential glaucoma patients are unaware of the presence of the disease. In most instances there is autosomal dominant inheritance.

It is advisable that physicians test the intraocular pressure when performing routine physical examinations on adults. The test and equipment merely call for a surface anesthetic and an inexpensive tonometer. Ophthalmologists or eye residents will gladly demonstrate this simple test to a physician upon request.

The most common forms of this disease in adults are simple or open-angle glaucoma and acute or narrow-angle glaucoma. Narrow-angle glaucoma usually requires surgery, and this should be performed early in the course of the disease before ocular damage occurs. On the other hand, open-angle glaucoma is readily controlled by medication.

Pilocarpine is the chief drug employed in the treatment of glaucoma and was the first direct-acting cholinergic compound to be used in glaucoma therapy. A one percent solution of this agent will frequently constrict the pupil for a period of five to six hours. If pilocarpine fails to control the intraocular tension the ophthalmologist will prescribe either the short-lasting physostigmine or the long lasting carbachol, isofluorophat, echothiophate, and demecarium bromine.

If the administration of miotics and epinephrine does not control the open-angle glaucoma, the surgeon will then attempt to reduce the rate of aqueous formation. In mild types of this disease the carbonic anhydrase inhibitors (acetazolamide, methazolamide, dichlophenamide and ethoxzolamide) will aid in controlling the intraocular pressure. If these agents are ineffective the surgeon may employ cryocyclotherapy. This painless procedure (cryocyclotherapy) may even be performed as an office procedure requiring only a few drops of a surface anesthetic. The technique is simple. The ophthalmologist places the tip of the cold applicator (at about -100°C) to the region of the ciliary processes and ciliary body (4 to 5mm from the limbus of the cornea). Freezing at very low temperatures causes atrophy of the ciliary body and ciliary processes and thereby reduces the amount of aqueous formation. This cryosurgical procedure is particularly effective in elderly patients in whom the ciliary body

and processes are already partially atrophied.

The Crystalline Lens

One of the major causes of impaired vision in adults over 65 years of age is cataract. In recent years a great amount of information has been developed on the biochemistry of the clear and cloudy crystalline lens. In addition, the electron microscope has been of great value in establishing the architecture of the lens.

The lens is an excellent osmometer. When excessive glucose, drugs or toxins reach the aqueous humor its osmotic pressure is increased. This withdraws water from the lens. When normal osmotic levels are restored, the increased concentration of the aforementioned substances attracts water to enter the lens. These osmotic changes in the lens: dehydration, hydration, and return to normal are accompanied by corresponding transitory refractive changes: myopia, hyperopia, and restoration of the normal refractive state.

The lens which originates from the surface ectoderm differs from the skin in that the oldest cell fibers are in the center and the youngest cell fibers are most superficial. Since lens fibers remain within the lens capsule throughout the life of the individual any traumas in the broadest sense, i.e., metabolic disturbances, toxins and radiation, leave a permanent mark. These changes make the lens an excellent sensitometer and chronometer. The mark in the form of an opacity corresponds to the time in life when the injury occurred. From this, the experienced ophthalmologist is able to estimate the approximate date of the opacity with the biomicroscope. The technique of dating the opacity in the lens is termed phakochronology (Gk. phakos = lens—chronos = time). This technique is of special importance in settling medicolegal disputes.

Cataract Surgery

In recent years many dramatic improvements have made cataract surgery simple and safe so that patients no longer need to fear this type of surgery.

Eliminating the technical details of surgery, the most important improvements have been 1) cryoextraction which permits the surgeon to obtain a superior grasp on

the lens, practically eliminating capsular rupture and permitting removal of the lens through a smaller incision; 2) physical or enzymatic zonulolysis to free the lens from its attachments; the latest development in this area has been hydrokinetic zonulolysis in which the surgeon uses sterile balanced salt solution to rupture the zonules; 3) improved needles and suturing materials, allowing the surgeon to close the wound and to make the anterior chamber air-and-water-tight; this permits early ambulation; 4) neuroleptanalgesia produced by the newer drugs places the patient in a state of basal anesthesia; this permits the surgeon to operate on a tranquil and cooperative patient.

Thus cataract surgery has become so refined and safe that even the very infirm and elderly patient may have his sight restored once again to see the faces of his family and friends and to resume the normal activities within his physical capabilities.

Retinal Detachment

Retinal detachment is the separation of the retina from the underlying pigment layer resulting from a tear or a hole in the retina. These holes or tears usually result from degenerative or myopic thinning of the retina. Fluid enters through the retinal hole, raising the retina and producing loss of vision.

Surgery is the only effective treatment, yielding successful repairs in 80-90%. Unfortunately, the surgical result is not always accompanied by a restoration of the visual acuity to its former state, especially if the macula area has been involved. The good surgical results are attributable to better materials and implants and improved technical procedures including the application of low temperature instead of diathermy to produce adhesive chorioretinitis to seal the holes.

Ocular Complications of Diabetes Mellitus

Better medical management of diabetes extending the life span of the diabetic has led to an increase in the incidence of ocular complications. The two major ocular complications are diabetic retinopathy and cataract.

The incidence of diabetic retinopathy increases with the duration of the disease.

Thus, if the onset of the diabetes occurs in a young individual, retinal changes will likely develop within a period of 16 to 18 years. Similar changes occur in the vessels of the kidney and other organs. All forms of treatment are relatively ineffective, including ablation of the hypophysis, the use of lipotropic agents, vitamin therapy, and radical changes in the diet. Some ophthalmologists report that sealing the areas of retinal leakage by photo-coagulation reduces the edema of the macula and improves the visual acuity. Other ophthalmologists doubt the value of photocoagulation. Recently Fabrykant and his co-workers reported that a high-protein-low-fat diet together with carbazochrome (Adrenosol Silicylate)* and anabolic steroids will cause an improvement in the retina and in the visual acuity.³

Diabetic cataract is seen only in juvenile diabetics. In older individuals the cataracts that form are indistinguishable from the ordinary senile cataracts. The treatment of cataract is surgical removal. The results in diabetics depend upon the condition of the blood vessels of the iris and retina. In the absence of retinal involvement and rubeosis irides, cataract surgery in diabetics offers no special problems.

Vascular Diseases of the Retina

Pathological changes in the retinal vasculature occur not only in diabetes mellitus but are also common in hypertension and arteriosclerosis. The importance of examining the fundus of the eye is that hypertensive and arteriosclerotic changes observed in the retina are paralleled by similar alterations in the renal vessels. Thus the physician obtains valuable information as to the state of the vessels in the kidney by ophthalmoscopic examinations.

There are four stages of hypertensive vascular disease: In the early stage, hypertensive arteriolo-retinal vessels are somewhat narrower than normal; they will appear "coppery." In stage II the attenuation of the arteriolar vessels becomes more pronounced. Focal areas of marked constrictions indicate local vascular spasms. In stage III, edema and flame-shaped hemorrhages make their appearance. Finally, stage IV shows the additional feature of edema of the optic disc.

*SEMED Pharmaceuticals.

In a recent report, Wendland states that the degree of hypertension is more important than age as a factor in the production of arteriolosclerosis. Diabetes mellitus, if present, accelerates the rate of progression of arteriolosclerosis.⁴

Venous obstruction. Obstruction of the central retinal vein may come on with dramatic suddenness with almost complete blindness. The ophthalmoscopic findings are so distinctive that, when associated with sudden loss of vision, they make the diagnosis unmistakable. The physician viewing the fundus with an ophthalmoscope will observe the marked dilation of the veins accompanied by "brush-stroke" hemorrhages in the retina. If only a tributary vessel is involved the above findings are localized in that area.

Until recent years, treatment was limited to the use of anticoagulants and the occasional use of fibrinolytic enzymes with generally poor results. Recently an important advance in therapy was reported when Radnot demonstrated that the intravenous administration of dextran produced a striking rate of recovery.⁵ This was especially true if treatment was begun early. It is now recognized that a great many strokes are actually the result of carotid occlusion. Among the early warning symptoms of impending closure of the carotid artery are signs of transient ipsilateral loss of vision and even homonymous hemianopsia. These ocular symptoms may be accompanied by transitory hemiplegia. When these signs are present it is imperative that ophthalmodynamometry be employed to determine the patency of the carotid arteries.

Ophthalmodynamometry may be performed either by pressure on the globe or by suction.⁶ With the ophthalmoscope the physician observes the point at which pulsations begin in the retinal arterioles; this reading indicates the diastolic pressure. The procedure is continued until the retinal vessels cease to pulsate; this reading indicates the systolic pressure. A significant difference in the values of the two sides indicates impending carotid obstruction.

Treatment consists of the administration of anticoagulant drugs before the carotid artery becomes occluded. If necessary, surgical intervention may restore normal blood flow to the brain and eye.

Ocular Toxicity of Drugs

Numerous drugs have a toxic effect upon the eye either when applied topically or when used systemically. The harmful effects of prolonged local applications of commonly used eye drops which are generally considered harmless has long been known. This is especially true when the epithelium has been denuded by trauma or extrusion as a result of an infection.

In most cases, a physician is well advised to treat a simple corneal abrasion due to trauma by merely lavaging the eye, applying a patch, and observing the eye daily. In many instances the eye usually heals without further treatment. On the other hand, repetitive applications of eyedrops in the presence of an epithelial defect may inhibit healing and cause permanent scarring. Drugs that inhibit healing and produce permanent scarring in the presence of a corneal abrasion include topical anesthetics, silver proteinate, zinc sulphate, sulfonamides and antiviral agents.

The physician should be especially cautious when prescribing eye drops containing corticosteroids because their prolonged use may lead to increased intraocular pressure or precipitate an acute attack of herpesvirus keratitis. It is also known that long-term application of certain miotics may produce lens opacities. Finally, alpha chymotrypsin, which is used by some in cataract surgery, may cause glaucoma and clouding of the cornea.

Systemic drugs. The prolonged systemic use of corticosteroids may produce cataracts. Optic atrophy and loss of vision has followed the use of quinine. Chloroquine, used in the treatment of malaria, arthritis and lupus erythematosus may be deposited on the corneal epithelium. Frequently a more serious and irreversible complication in the form of pigmentary degeneration of the retina occurs. Common psychotherapeutic agents such as the phenothiazine drugs may produce retinal changes as well as deposits on the cornea and lens. Digitalis intoxication producing blurred vision and central scotomas has been reported; recovery follows the discontinuance or reduction of the quantity. Oral contraceptives have been reported to have a significant relationship to thrombophlebitis in the legs and elsewhere and have been frequently associated with pulmonary embolism. Less known

are the ocular complications either as a result of cerebrovascular accidents or a result of neuro-ocular involvement producing optic neuritis and extra-ocular muscle paresis with diplopia. Ethambutol, a drug used in the treatment of pulmonary tuberculosis, may produce involvement of the neuro-optic pathways.

Chemical Burns

In these days of violence chemical burns of the eye are becoming more common. Mace, used by law enforcement officers, can cause chemical burns of the eye. Intentional or accidental alkali and acid burns call for immediate emergency measures. The victim should immediately flush the eye with water or any inert fluid that is available, such as milk, to remove the chemical agent. The time interval that elapses before lavage is performed is frequently the most important factor that determines the degree of damage that follows a chemical burn. The author treated a woman who had been burned by lye deliberately thrown into her eyes. She had the presence of mind to reach for a milk bottle on a nearby doorstep. She poured the contents into her eyes within a matter of seconds. Undoubtedly the immediate washing out of the toxic material contributed to the lack of permanent damage.

It is generally known that alkalis cause far more damage to the eye than acids. Since it is also known that it requires a longer period of time to restore the normal pH of the cornea, washing with water (ordinary tap water will do) should be carried on for at least thirty minutes. Further treatment depends upon the amount of damage sustained by the cornea, conjunctiva and the lids. Necrosis of these tissues frequently requires special therapy including surgical procedures.

Eyeliner applied to the lashes by women causes a chronic conjunctivitis and pigmentation of the conjunctiva. Biopsy of the pigmented conjunctiva shows microscopically dense infiltration with lymphocytes and macrophages containing pigmented granules.

Dyslexia

A deficiency or disturbance in the ability to read is termed dyslexia. Poor readers and children with true dyslexia are frequently

brought to the physician for examination and advice.

Ordinarily children learn to read either by recognizing an entire word (the "look-say" method) or by the arrangement of the individual letters and their sound (the "phonics method"). Some children use a combination of both methods to learn to read.

Dyslexia may be manifested in the following ways:

- 1) The child cannot recognize the printed word, but he understands its meaning when the word is spoken;
- 2) The child recognizes and understands the printed word, but not the meaning when it is spoken;
- 3) The child recognizes individual letters but cannot put them together to form a word;
- 4) The child knows the word but cannot recognize the individual letters;
- 5) The child is able to read and understand the printed word and can hear and understand the spoken word, but he cannot associate one with the other.

The pediatrician confronted with a young child having reading difficulties should assume the leadership of a multi-disciplinary team comprising specially trained teachers, psychologists, and social service workers. The role of the ophthalmologist is to determine the presence or absence of ocular defects or abnormalities which might be contributing factors. The otologist and the psychologist should determine the status of the child's hearing and intelligence. The social workers should search for family problems, disadvantageous cultural climate, poor teaching, or emotional disturbances that may play a role in the child's reading deficiency.

Amblyopia

Strabismus or deviation of the eye present after the sixth month of life should be treated promptly if amblyopia is to be avoided. In unilateral deviation, the infant may use one eye to see and suppress vision in the other. In such instances, the squinting eye will not develop properly. Patching the good eye must be prescribed early to force the child to use the squinting eye to avoid irreparable damage.

Hubel and Wiesel recently demonstrated in the cat that occlusion of one eye caused

a sharp reduction in the actual number of visual cells in the retina, the geniculate body, and the striate area of the cortex. After three months of occlusion, recovery or improvement did not occur.⁷ Similarly an infant with a deviating eye and total suppression that is untreated until the child is 4 or 5 years of age will rarely have more than 20/200 visual acuity. On the other hand, a child with normal sight up to 6 or 8 years of age who develops a paralytic or non-paralytic strabismus retains his sight, no matter how long the eye remains deviated. The physician must remember that a child does not outgrow a squinting eye and that very early therapy is necessary to avoid amblyopia.

Emerging Developments in Ophthalmology

The dynamic nature of ophthalmology is nowhere more apparent than in the stream of new ideas and developments that are constantly being presented for consideration. Among the most noteworthy developments, briefly mentioned, are:

- Ophthalmologists have begun to question the belief of lighting engineers that "the most light is the best light." Eye physicians now report that over-illumination may be harmful to the retina.

- Keratoprostheses. Patients almost blind from diseases of the cornea are treated by the implantation of an acrylic lens in the cornea. This frequently results in the restoration of useful vision.

- New methods to help the blind. New devices are being developed with the hope that the blind may regain 1) some measure of restored visual imagery or 2) some substitute for sight. Principles involved are the use of radio receivers which are connected to electrodes in contact with the visual cortex or to substitute the skin's sensory stimuli for the lost visual stimuli.

- Retinoblastoma. Formerly malignant retinoblastoma in children was an indication for early enucleation. Now with the aid of newer techniques the eyeballs may be retained. This is especially important when both eyes are involved.

- Non-magnetic foreign bodies which were previously impossible to remove from the eye are now being extracted by using low-temperature techniques. In this new procedure the tip of a low-temperature probe is placed in a position so that it comes in contact with the foreign body. The latter becomes fused to the cold tip and is withdrawn from the eye. If vitreous is lost and the eyeball is collapsed following a penetrating injury, eye surgeons may restore the fullness of the eyeball by substituting a balanced salt solution for the vitreous.

- Ophthalmologists as well as most other physicians have shown an increasing concern with the problem of automotive medicine. A multidisciplinary approach to the problem has already yielded information to help reduce the physical damage and to improve the treatment of patients involved in automobile accidents.

- Angiography. The injection intravenously of 5% solution of sodium fluorescein is now being used by many ophthalmologists. The fluorescein dye aids in delineating vascular abnormalities, leakage from vessels, edema of the retina, abnormalities of the optic nerve disc, and in differentiating microaneurysms from hemorrhages. ◀

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186 to 8 to ?

It took 186 years from the Declaration of Independence until 1962 before our Federal Government spent \$100 billion in one year. But it took only eight more years for the annual budget to rise a second \$100 billion, up to \$200 billion.

Counter-Measures Against Narcotic Addiction

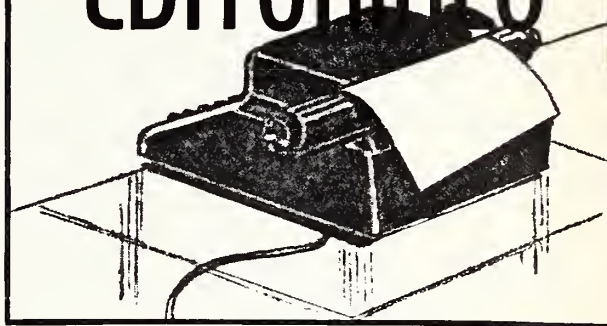
Parents must confront each of their adolescent children with the dangers of taking narcotics. Dr. D. W. Winnicott, a British psychiatrist, recently has stated that adults are derelict in their duty if they ignore or lamely submit to the attitudes of the present generation of adolescents. Confrontation can be a valuable technique parents need in facing the tidal wave of drug addiction that threatens to inundate the present generation. Confrontation techniques have been extensively studied by Dr. Harry Garner, head of psychiatry at Chicago Medical School. The confrontation technique involves the use of a strong, positive exclamatory sentence followed by a question.² An example would be "I never want you to take narcotics." "What do you think or feel about what I've told you?" Hopefully this will stimulate the pre-adolescent to listen and to discuss the dangers of taking drugs and maintain a dialogue on the subject with his parents. It is most important that the confrontation begin in pre-adolescence, before the child has been exposed to the powerful "peer group pressure" of high school and college.

The National Institute of Mental Health has also been looking into more effective ways to change adolescent attitudes toward the use of narcotics.³ The newly proposed program will no longer emphasize the negative aspects such as the dangers and side effects of taking drugs.

The new approach is to show teenagers the stupidity of taking drugs and the exposure of addicts to ridicule. A spokesman for the agency in charge of the new campaign for NIMH states that as much as he dislikes slogans they may be effective in modifying adolescent attitudes. He suggested, as a possible slogan: "Why do you think they call it dope?" To this rather weak effort we can add "Don't be an ass; Keep off grass." "Don't be duped by dope." "Would you want your appendectomy done by a speed taking surgeon?" "Would you fly with an airline pilot high on LSD?"

Picture the following statement as a possible poster. "Don't be duped, tricked, rooked, badgered, led, misled, forced, bribed, trapped, lured, enticed, enchanted, euchered, talked, ensnared, bamboozled, coerced, cajoled, fooled, flattered, deceived,

EDITORIALS



hood-winked, challenged, harassed, bluffed, coaxed, shamed, teased, tantalized, manipulated, bulldozed, pressured, persuaded, hounded, pestered, seduced, terrorized, blackmailed, threatened, driven, pushed, inveigled, nagged, cozened, suckered, goaded, railroaded, beguiled, induced, into taking
-----dope."

The use of these slogans can only be the beginning of the battle against the spread of narcotic addiction. A campaign similar to the highly successful one the American Cancer Society has developed is urgently needed. Local communities should consider conducting, with students and civic organizations, an anti-drug abuse day.

The medical profession should join with government agencies, private foundations, large corporations and the communications media in launching a coordinated counter-attack against the insidious spread of drug addiction in the United States.

Harvey Kravitz, M.D.

References

1. Winnicott, D. W., "Adolescent Process and the Need for Personal Confrontation." *Pediatrics* 4:752, 1969.
2. Garner, H. H., "The Confrontation Problem Solving Technique: Developing a Psycho-Therapeutic Force." *American Journal of Psychotherapy* 24:27, 1970.
3. Sanford, D., "Unselling Drugs," *New Republic*, February 28, 1970, p. 15.

Pulmonary Function Evaluation

Many tests are available for evaluating pulmonary function. The majority of these procedures are sophisticated and best performed by physicians specially trained in pulmonary physiology. In recent years, the demand for these tests has increased due to

the high incidence of chronic bronchitis and emphysema. Cigarette smokers with a chronic cough or dyspnea should have pulmonary function studies made as part of their total health evaluation. The procedures may provide the definite objective evidence that will encourage the smoker to quit.

How much pulmonary function equipment should the clinician buy for his office? For those who are not specialists in chest diseases, a spirometer is the only piece of equipment that is needed. The patient should be referred to the pulmonary laboratory if more extensive tests are needed. Many types of spirometers are available; the quality is in proportion to the cost. The most satisfactory are sturdily constructed, have a low apparatus resistance, and are convenient to use. The paper speed should be sufficient to make accurate measurements.

Spirometry determines restrictive and obstructive types of ventilatory insufficiency. The restrictive type is due to loss of ventilable lung tissue resulting from inflammation or fibrosis. Loss of lung parenchyma may also stem from destruction or resection of lung tissue, heart failure, or chest wall disease. Parenchymal changes also occur in emphysema and parallel the loss of

elastic recoil of the lungs as the destructive process progresses. The vital capacity is measured by having the patient inhale as deeply as possible and exhale slowly into the machine until there is no further flow. This value is compared to that of normal individuals of the same age and height.

Obstructive ventilatory insufficiency usually results from asthma, bronchitis, or emphysema. There is an increase in the resistance to air flow within the bronchial tree. The forced vital capacity (FVC) is obtained by exhaling rapidly and forcibly to the point of no flow. Many measurements can be obtained from this curve which are then compared to predicted values. Maximum voluntary ventilation (MVV) can also be obtained by having the patient breathe as vigorously and rapidly as possible for 15 seconds. In this way the volume exhaled during three or more breaths is recorded. This is checked against known standards.

The spirometer is not infallible and the results should always be correlated with clinical findings. This is understandable because the results are influenced by the patient's volitional efforts. All of these factors must be considered to avoid overdiagnosis of respiratory diseases.

T. R. Van Dellen, M.D.

Search for Metabolic Lesion

The exact metabolic lesion in cystic fibrosis has not yet been discovered. Approximately one of every 2,000 persons born in the United States is afflicted with this generalized disorder of exocrine glands, characterized by excessive mucus production and inability of the ducts of sweat glands to reabsorb sodium, chloride and potassium. Chronic pulmonary disease is responsible for most of the morbidity and mortality. A few of the patients succumb to abdominal complications—in some cases as neonates with meconium ileus, in others later in life as a result of intestinal obstruction or secondary to a characteristic biliary cirrhosis. Attempts to explain these striking and devastating clinical features have recently led to significant advances in knowledge, providing clues for the search for the metabolic defect in cystic fibrosis. (Richard C. Talamo, M.D., "Cystic Fibrosis of the Pancreas—New Clues to the Metabolic Riddle." *California Medicine* 110:5 [May] 1969.)

Suggestions Offered

Is the quality of service in your hospital, the efficiency of operation, and the well-being of patients less than desirable? Are there too many indifferent employees? This administrator offers some suggestions for a program to eliminate these and other problems. (Clyde T. Hardy, Jr.: "A Staff Meeting I Would Like to Attend." *Physician's Management* [June] 1969.)

130th annual convention

illinois state medical society
may 17-20, 1970
sherman house, chicago

**Highlights of Convention
Elections
Actions of House Delegates**

1970-1971 OFFICERS AND BOARD OF TRUSTEES

Officers

President	J. Ernest Breed, 55 E. Washington St., Chicago 60602
President-elect	L. T. Fruin, 5 Citizen's Square, Normal 61761
1st Vice-President	George Shropshire, 1525 E. 53rd St., Chicago 60615
2nd Vice-President	C. J. Jannings III, 101 E. Center St., Fairfield 62837
Secretary-Treasurer	Jacob E. Reisch, 1129 S. 2nd St., Springfield 62704

House of Delegates

Speaker of the House	Paul W. Sunderland, 214 N. Sangamon St., Gibson City 60936
Vice-Speaker	Andrew J. Brislen, 6060 S. Drexel Blvd., Chicago 60637

Trustees

1st District	1971	Joseph L. Bordenave, 1665 South St., Geneva 60134
2nd District	1971	Wm. A. McNichols, Jr., 101 W. 1st St., Dixon 61021
3rd District	1971	William M. Lees, 6518 N. Nokomis, Lincolnwood 60646
	1971	Frank J. Jirka, Jr., 1507 Keystone Ave., River Forest 60305
	1972	Warren W. Young, 10816 Parnell Ave., Chicago 60628
	1972	Fredric D. Lake, 1041 Michigan Ave., Evanston 60202
	1973	James B. Hartney, 410 Lake St., Oak Park 60302
	1973	Frederick E. Weiss, 15643 Lincoln, Harvey 60426
4th District	1973	Fred Z. White, 723 N. Second St., Chillicothe 61523
5th District	1973	A. Edward Livingston, 219 N. Main, Bloomington 61701
6th District	1972	Mather Pfeifferberger, State & Wall Sts., Alton 62002
7th District	1973	Arthur F. Goodyear, 142 E. Prairie St., Decatur 62523
8th District	1973	Eugene P. Johnson, 22 W. Main St., Casey 62420
9th District	1972	Charles K. Wells, 117 N. 10th St., Mt. Vernon 62864
10th District	1972	Willard C. Scrivner, 4601 State St., E. St. Louis 62205
11th District	1971	Joseph R. O'Donnell, 444 Park, Glen Ellyn 60137

Trustee-at-Large	Edward W. Cannady, 4601 State St., E. St. Louis 62205
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Chairman of the Board	Willard C. Scrivner, 4601 State St., E. St. Louis 62205
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CONVENTION HIGHLIGHTS



Addressing the House of Delegates was Dr. Edward W. Cannady, ISMS president.

ATTENDANCE TOTALS

Attendance at the 130th Annual Meeting was as follows:

Physicians	1,516
Guests	256
Auxiliary	242
Exhibitors	347
Medical Students	76
Allied Health Personnel	260
Total	2,697

AD HOC REFERENCE COMMITTEE ADDED

A new and special reference committee was added this year to enable medical students to express their views and opinions.

MEMORIAL SERVICE HELD

Jacob E. Reisch, M.D., ISMS secretary-treasurer, conducted a brief memorial service for the 172 deceased ISMS members. For the first time this past year personal notes of condolence were sent to families of deceased members from ISMS.

SAMA OPINIONS EXPRESSED

Lee Fischer, medical student and SAMA Midwest Regional Vice-President, the University of Illinois, addressed the House and reviewed SAMA's involvement on the medical scene. Mr. Fischer expressed the concern SAMA members feel over the relevancy of such projects as MECO and better health care, compared to the effort spent on the war. In directing his remarks to the House, Mr. Fischer asked that students not be ignored if they are to work together with members of ISMS in solving problems of health care for all the people.

IMAA PRESIDENT REPORTS TO THE HOUSE

Miss Ina Yenerich, president of the Illinois Medical Assistants Association, reviewed the past year's activities and cited the increase in membership due to the workshops sponsored in conjunction with the President's Tour. She concluded her remarks in noting that the patients will benefit most from close coordination between doctors and medical assistants.

MRS. ARNOLD REVIEWS AUXILIARY'S PROGRESS

Mrs. Sherman Arnold, president of the Woman's Auxiliary to the ISMS, cited the primary objective of the Auxiliary as supporting the ISMS program. Auxiliary participation in the President's Tour was the highlight of the past year. In behalf of the 3,100 members of the Auxiliary, Mrs. Arnold presented to Dr. Cannady, a check in the amount of \$7,934.09 for Benevolence.

DR. THOMSEN GIVES IMPAC REPORT

Dr. Philip Thomsen urged members of the House to identify and offer solutions to the social, economic and medical problems besetting doctors before they lead to government intervention. Physicians should cooperate with the government in providing medical leadership. They should also participate in political campaigns through financial contributions and campaign manpower.

He discussed IMPAC's effectiveness and urged more doctors to join IMPAC, especially from Cook County where the participation is less than from other counties. He noted that of the 369 legislative bills presented in Illinois this past year, 90 were bills directly affecting physicians and medicine, which once again emphasized IMPAC's necessity on the legislative scene.

ISMS PRESIDENT'S REPORT

Dr. Edward Cannady commented on his role as chief spokesman of ISMS on problems such as rising costs of health care, training and keeping more doctors in Illinois, and alleviating the doctor shortage by sponsoring and supporting legislation establishing a Department of Family Medicine at the University of Illinois. He also cited ISMS's role in securing a state appropriation for medical school expansions, including \$6 million to the Chicago Medical School which will double the school's enrollment. The Society also supported creating a medical school for Southern Illinois University and other schools in the downstate area.

Dr. Cannady urged physicians to vote in favor of an independent Council on Continuing Medical Education and called for support of the medical profession in other programs to provide effective and economical health care.



Dr. Philip Thomsen, chairman of the IMPAC Board, addresses his remarks to the delegates at the first session of the House.



Dr. Leon O. Jacobson, dean, Pritzker School of Medicine, The University of Chicago, accepts a check on behalf of Illinois' five medical schools from President Edward W. Cannady. The check, in excess of \$120,000, was contributed by ISMS members as designated AMA-ERF dues.

DR. CANNADY PRESENTS AMA-ERF FUNDS

Approximately \$120,000 representing the total AMA-ERF collection for Illinois Medical Schools was presented to Dr. Leon Jacobson, dean, Division of Biological Sciences, Pritzker School of Medicine, University of Chicago, for distribution.

EDMUND F. FOLEY ACCEPTS HAMILTON TEACHING AWARD

Dr. Edmund F. Foley, emeritus professor of medicine, University of Illinois College of Medicine, received the Hamilton Teaching Award for his outstanding qualities as a teacher of medical students. A plaque and \$500 cash award was presented to him by Dr. George B. Callahan, a member of the Board of Trustees of the Interstate Postgraduate Medical Association.

POLITICAL SATIRIST ADDRESSES PUBLIC AFFAIRS DINNER

Art Buchwald, satirist and newspaper columnist, delivering the Camp Memorial lecture, delighted those in attendance at the Seventh Annual Public Affairs Dinner in speaking on "The Establishment Is Alive and Well and Living in Washington." U. S. Senator Ralph T. Smith was also present at the dinner and spoke briefly on current problems being contemplated by the U.S. Congress.

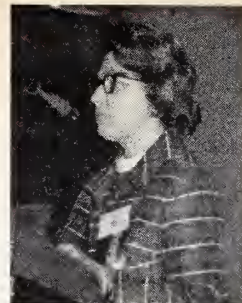
PRESIDENT'S BANQUET A HIGHLIGHT OF CONVENTION

The premier social event of the convention—the President's Reception and Banquet—was held on Tuesday evening, honoring Dr. Edward W. Cannady for a highly successful year as ISMS president. Entertainment was provided by the Frankie Masters Orchestra and songstress Grace Markay.



The Hamilton Teaching Award was presented to Dr. Edmund F. Foley, (right) professor emeritus of medicine, from the University of Illinois College of Medicine, by Dr. George B. Callahan, trustee of the Interstate Postgraduate Medical Education Association.

Mrs. Sherman Arnold, president, the Woman's Auxiliary to ISMS, speaks to the House of Delegates at the ISMS annual meeting.



DR. MORRIS FISHBEIN ADDRESSES 50 YEAR CLUB LUNCHEON

Dr. Morris Fishbein, world-famous author and former editor of *JAMA* compared today's medical students with those of his day, noting the striking similarities. In addition, 39 new members were initiated into the club and presented with awards by Dr. Edward W. Cannady.

J. ERNEST BREED INDUCTED AS PRESIDENT

Dr. J. Ernest Breed was inducted as president of the ISMS at the third House of Delegate's session. Administering the oath of office was outgoing president, Dr. Edward W. Cannady.

Afterward, Dr. Breed presented his inaugural speech emphasizing:

- Immunization programs for needy pre-school children;
- Group practice in rural areas;
- Peer Review;
- Malpractice and
- Continuing medical education.

In summation Dr. Breed said, "My aspiration for the year ahead revolves around 'how can we make things happen?'—not 'what is happening to us?'"

COUNTY MEDICAL SOCIETIES RECOGNIZED FOR IMMUNIZATION PROGRAMS

Dr. Franklin D. Yoder, director, Illinois Department of Public Health, commended the trustees for their support in developing immunization programs. Special emphasis has been placed on vaccinating susceptible individuals such as pregnant women as well as children in kindergarten through third grade. He commended the many county societies which have conducted immunization programs.

AMA PRESIDENT-ELECT COMMENTS ON AMA SCENE

Dr. Walter C. Bornemeier announced that two, 30 minute documentaries are being produced by the AMA



Dr. Edward W. Cannady, past-president from East St. Louis, pauses to admire the President's Medallion he has just presented Dr. J. Ernest Breed, at the closing session of the ISMS annual meeting.



Feted at the Annual Past Presidents' Dinner, for 34 years with ISMS, was Mrs. Frances C. Zimmer, executive assistant. (Standing from left), Drs. Arkell M. Vaughn, Caesar Portes, Edwin S. Hamilton, Edward A. Piszczek, George F. Lull, Harlan English, Philip G. Thomsen, H. Close Hesseltine, Newton DuPuy, Jacob E. Reich (host). Seated, Dr. Everett P. Coleman, Mrs. Zimmer, Dr. James H. Hutton.

to counteract the biased programs on health care presented by the CBS network.

He forecast the partial alleviation of the doctor shortage with the opening of new medical schools and called attention to current residency programs which do not prepare physicians to care for the sick outside of hospitals.

SCIENTIFIC EXHIBIT AWARDS PRESENTED TO EXHIBITORS

- Gold Award**—The Anatomic Basis of Groin Hernia Repair,
Robert E. Condon, M.D., Department of Surgery, University of Illinois, College of Medicine.
- Silver Award**—A Demonstration of Normal Temporal Bone Anatomy and the Histopathology of Common Inner Ear Disorders.
John R. Lindsay, M.D.,
Horst R. Konrad, M.D.,
Midwestern Temporal Bone Banks Center.
- Bronz Award**—Subtraction Technique with Color Addition.
A. K. Bonk, M.D.,
Edgewater Hospital

NEW OFFICERS ELECTED FOR 1970-1971

The House of Delegates elected the following officers and trustees:

President elect L. T. Fruin, Normal



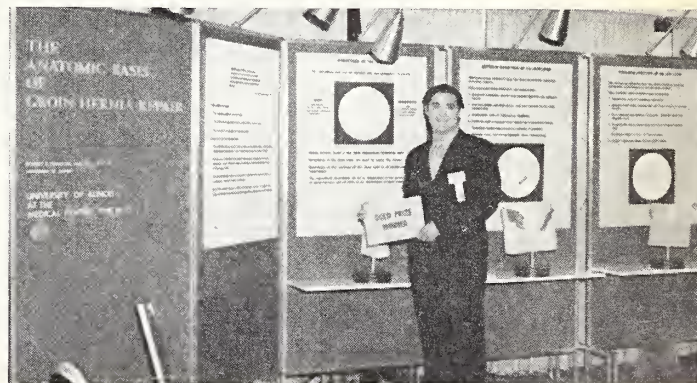
Dr. R. Kent Swedlund, Watseka, the first to register at the 130th annual meeting, was greeted by staff member, Betty Lynch.

- | | |
|------------------------|-----------------------------------|
| 1st Vice President | George Shroppshear, Chicago |
| 2nd Vice President | C. J. Jannings III, Fairfield |
| Sec'y-Treas. | Jacob E. Reich, Springfield |
| Speaker of the House | Paul W. Sunderland, Gibson City |
| Vice Speaker | Andrew J. Brislen, Chicago |
| Trustees elected were: | |
| 3rd District | James B. Hartney, Oak Park |
| 3rd District | Frederick E. Weiss, Chicago |
| 4th District | Fred Z. White, Chillicothe |
| 5th District | A. Edward Livingston, Bloomington |
| 7th District | Arthur F. Goodyear, Decatur |
| 8th District | Eugene P. Johnson, Casey |

AMA DELEGATES ELECTED

Members of the AMA Delegation elected for two-year terms beginning January 1, 1971, were Maurice M. Hoeltgen, Francis W. Young, H. Close Hesseltine, Carl E. Clark and Joseph R. Mallory. Alternate delegates elected were Theodore VanDellen, Fred A. Tworoger, Frank J. Jirka, Jr., Joseph O'Donnell and Jack Gibbs.

Harold A. Sofield was elected to serve the unexpired term of Walter C. Bornemeier as delegate, to take office immediately. Alternates elected to fill unexpired terms were Boyd McCracken, Glen Tomlinson, Herschel L. Browns and William M. Lees.



The Gold Scientific Award was given to Dr. Robert E. Condon, from the Department of Surgery, University of Illinois College of Medicine for his exhibit, "The Anatomic Basis of Groin Hernia Repair."



Art Buchwald, political satirist and columnist was the center of attention after his humorous presentation of "The Establishment Is Alive and Well and Living in Washington," at the Seventh Annual Public Affairs Dinner. Meeting the speaker were (from left), Dr. Paul Theobald, Dr. L. T. Fruin, Art Buchwald, Dr. Theodore Grevas, and Tony Holloway, Journalism Fellowship recipient.

STAFF HONORED

James Slawny, director, Division of Public Relations and Economics, received a plaque in recognition of initiative, originality and outstanding achievement in public relations programming.

Mrs. Frances C. Zimmer also was honored with a plaque in recognition of her 34 years of service to ISMS.

HOUSE TACKS \$2 ON DUES

The House accepted the recommendation of the Board of Trustees that the 1970 dues remain unchanged at \$105. However, upon recommendation of the Reference Committee on Education & Community Health Services, the House approved a special one-year assessment of \$2 to

cover the production and mailing cost of sending the *Illinois Medical Journal* and *Pulse* to all SAMA members attending Illinois Medical Schools.

REFERENCE COMMITTEE CHAIRMEN

Constitution & Bylaws	Glen E. Tomlinson, Lincoln
Officers & Administration	Charles U. Culmer, Waukegan
Finances, Budgets & Publications	Francis W. Young, Chicago
Legislation & Public Affairs	Charles N. Salesman, Robinson
Education & Community Health Services	Lawrence L. Hirsch, Chicago
Economics & Social Services	R. K. Swedlund, Watseka
Public Relations & Misc. Bus.	Fred A. Tworoger, Chicago
Ad Hoc	Robert E. Heerens, Rockford



Fifty Year Club members gathered together for a group picture were (from top left), Drs. Carl F. Steinhoff, Proctor C. Waldo, Raymond S. Shurtleff, Max E. Engerman, Peter J. Werner, Joseph J. Litschgi, Norbert Pauker, (bottom, from left) Arthur R. Bogue, Woodruff L. Crawford, Henry F. Heller, Charles A. Learsy, Samuel M. Feinberg, Ralph A. Reis, Robert M. Graham, George E. Irwin.

SUMMARY OF ACTIONS OF THE HOUSE OF DELEGATES

I. REFERENCE COMMITTEE ON OFFICERS & ADMINISTRATION

The reports of Officers, Trustees, Chairman of the Board of Trustees, AMA Delegation, Executive Administrator, Speaker, Vice Speaker, Auxiliary President and Advisory Committee to the Auxiliary were received and accepted, with commendation for outstanding service to the Society.

In accepting the report of the Policy Committee, it was suggested that the Board of Trustees review the policy statement on "Hospital Records and Their Availability" in light of the current hospital procedure for supplying photocopies of records on request of Medicare intermediaries and other third parties.

Reports of the Policy Committee, the Committee on Committees, Committee to Study Osteopathic Problems and the Ethical Relations Committee were also accepted by the House.

IMPLEMENTATION OF PHYSICIANS LIABILITY PROGRAM

Resolution 70M-34 was adopted, which provides for the implementation of the program developed by the Physicians Liability Evaluating Committee. The program will involve a state-wide program on how to avoid malpractice suits and assistance to physicians threatened with

suits. The details of the program are subject to approval by the Board of Trustees.

INCREASED BOARD REPRESENTATION & JOINT MEETINGS

Acting upon a special amended report, the House approved the following:

A fifty percent increase in representation on the Board of Trustees from the 3rd District and no change in the composition of the House of Delegates.

That the House of Delegates direct negotiations aimed to bring about prompt amalgamation of the annual scientific meetings of the ISMS and of the Chicago Medical Society, and

That the Constitution & Bylaws Committee be instructed *Now* by the House of Delegates to submit the necessary recommended changes to the 1971 annual meeting of the House of Delegates. Under the change in representation the Board of Trustees will consist of 19 elected trustees (presently 16), four elected officers (with vote), and two vice presidents and one vice speaker (without vote).

II. REFERENCE COMMITTEE ON FINANCES, BUDGETS & PUBLICATIONS

The House accepted reports submitted by the Educational & Scientific Foundation, Publications Committee, Editorial Board, Editor of the *IMJ*, the annual audit and the Treasurer's Report. It also approved the report of the Benevolence Committee which included increased payments to a majority of recipients.

PROJECTED 1971 BUDGET

The House approved the Reference Committee recommendation that \$6.50 per each dues paying member be deducted from the previous \$8 allocation to the Permanent Reserves and be placed in the General Operating Fund to balance the 1971, projected budget. The House approved distribution of the dues dollar for 1971 as follows:

Operating Fund	\$77.50
Permanent Reserves	1.50
AMA-ERF	20.00
Benevolence	4.00
HCCI	2.00
	<hr/>
	\$105.00
Special assessment	
Publication, production and mailing <i>IMJ</i>	
for SAMA members	2.00
	<hr/>
Total	\$107.00

III. REFERENCE COMMITTEE ON CONSTITUTION & BYLAWS

PEER REVIEW

Approval was given to the establishment of peer review under the Bylaws. Each component society shall have, by appointment or election, a Peer Review Committee whose duty it shall be to review all proper complaints and inquiries brought before it by physicians, patients, institutions, insurance carriers or government

agencies. In other specific action the House of Delegates:

Passed a resolution authorizing the Board of Trustees to request that all undesignated AMA-ERF funds from ISMS dues allocation be equally divided among Illinois medical schools.

Rejected a resolution requesting that the \$8 allocation designated for the reserve fund be discontinued and instead be placed in a special fund for utilization in developing or implementing new programs recommended by the House.

Rejected a resolution calling for a dues increase, of which a certain amount would be allocated to finance SAMA activities and to reimburse those county medical societies with an executive office and staff.

Adopted a revised resolution asking the AMA delegates to introduce a resolution in the AMA House of Delegates requesting that the *JAMA* return to its former policy of omitting advertising from the editorial and scientific pages of the *JAMA*.

Rejected a resolution authorizing that all undesignated AMA-ERF funds from the ISMS dues allocation be awarded as a yearly prize to the medical school which has shown the greatest effort in increasing the number of Illinois physicians who go into private practice in rural communities and depressed city areas.

be established by the component society. The State Society committee will act upon appeals from the decisions of the county or district committees.

SAMA REPRESENTATION

Under the new Bylaws SAMA will be entitled to one delegate and one alternate delegate to serve in the House of Delegates, with full membership and voting privileges.

AMA DELEGATES ON COUNCILS OR COMMITTEES

Favorable action was taken on the resolution to permit AMA delegates to serve as chairmen or members of any council or committee. Voting members of the Board of Trustees may serve only as advisory members to any council or committee.

SEATING OF DELEGATES

Of particular significance for the 1971 annual meeting was the adoption of change in the principle of seating alternate delegates during the House of Delegate sessions. If a seated delegate is replaced by an alternate, he may not be seated again for that session, but he may be seated at subsequent sessions.

In other actions taken the House:

Referred to the Board of Trustees a resolution requesting affiliate status for the Illinois Chapter of the American College of Radiology and that such

affiliation entitle the chapter to representation in the House of Delegates.

Referred to the Board for further study a proposed change in the Bylaws which would establish affiliate societies with voting representation in the House.

Adopted an amended resolution which established the policy that the Committee on Committees shall function at the request of the Board rather than annually, to review and report on the committee structure.

Referred to the Board of Trustees the proposed amendments that the House of Delegates be the state society forum to set the philosophy of the Society; and

Referred to the Board of Trustees a resolution giving the House of Delegates authority to direct the Board of Trustees to spend funds for the implementation of programs.

Approved in principle a resolution to permit county medical societies to seek reimbursement from third party organizations for expenses incurred through peer review activities.

Adopted a resolution calling for ISMS to support the principle that county medical society peer review committees be the first source of appeal from decisions made by hospital or other medical facility review committees.

IV. REFERENCE COMMITTEE ON ECONOMICS AND SOCIAL SERVICES

The reports submitted by the Council on Economics and Governmental Health Programs, Council on Social and Medical Services, Committee on Disaster Medical Care and the Committee on Prepayment Plans and Organizations were accepted.

VISITING NURSING SERVICE UNDER MEDICARE

A resolution calling for a better understanding by the Blue Cross Medicare fiscal intermediary and Social Security Administration relative to payment for visiting nursing service was not approved. The House felt that this problem was due to a breakdown of communication and failure to comply with existing guidelines and offered several constructive suggestions.

ILLINOIS DEPARTMENT OF PUBLIC AID

The report of the Advisory Committee to the Illinois Department of Public Aid was accepted. The House expressed appreciation for information regarding its functions and for its outline of recommendations made to the Department.

Harold O. Swank, director of IDPA, called particular attention to:

(1) Payment for physical examinations and immunizations of underprivileged children in first, fifth and ninth grades.

(2) Payment of psychiatric services outside of mental hospitals as a future possibility.

(3) Extension of "medical only" eligibility for a limited time to selected cases leaving public aid rolls.

(4) Extension of family planning services.

The report of the Sub-Committee on Drugs and Therapeutics was also adopted.

DIVISION OF VOCATIONAL REHABILITATION

The Advisory Committee to the Department of Vocational

Rehabilitation was cited for its effects to establish an initial liaison with DVR. The recommendations of the 1969 House of Delegates calling for the establishment of guidelines to determine eligibility, and emphasizing referral to the DVR program by a physician was reaffirmed.

The Reference Committee recommended and the House of Delegates concurred, in requesting an investigation to determine the possibility of over-utilization of this program and the qualifications for eligibility. This matter should be submitted to the Advisory Committee on Medical Costs and Utilization of Services created by SB 1139, Illinois 76th General Assembly.

AGING

The report submitted by the Committee on Aging was accepted. Questions concerning intravenous treatments, collection of blood specimens for tests, and death certification raised by the Committee on Aging, were referred to the ISMS Medical Legal Council.

NURSING SCHOOL CERTIFICATION

The recommendation of the Committee on Nursing that certification of college-level medical paramedical educational curricula be transferred from the Department of Registration and Education to the appropriate governing board, was approved.

HEALTH CAREERS COUNCIL

Based on the report of the Advisory Committee to Paramedical Groups the House agreed that the financial support currently being given to the Health Careers Council, be continued at \$2 per dues paying member.

The recommendation that the physician liaison member to the Health Careers Council should be a member of the Advisory Committee to Paramedical Groups was also accepted.

HOSPITAL REIMBURSEMENT

Resolution 7M-50, calling for Blue Cross and the Department of Public Aid to use prospective rate negotiation as the method of hospital reimbursement, was adopted. The substance of this resolution will be submitted to the House of Delegates of the AMA when it convenes.

USUAL AND CUSTOMARY FEE COMMITTEE

The report of the Usual and Customary Fee Committee was adopted, including the request that county medical societies embrace the full range of fees of all physicians in the area as delineated by the usual, customary and reasonable definitions, in lieu of fee schedules or coefficients applied to relative value scales.

In specific actions taken on resolutions reviewed by this Reference Committee, the House:

Reaffirmed the concept of a contractual relationship existing only between the physician and patient, the necessity for consultation paid for by the insurance carrier, and the acceptance of physicians' fees which are "usual and customary," without implication of any overcharge as basic policies of the ISMS.

Rejected a resolution calling for the elimination of the Drug Manual prepared by the Sub-Committee on Drugs and Therapeutics.

Rejected a resolution seeking ISMS endorsement of the Attending Physician's Statement-Health Insur-

ance Claim-Group or Individual form as the only claim form to be completed by ISMS physicians after January 1, 1971.

Adopted, as amended, a resolution that, after January 1, 1971, a representative of a group, clinic, or corporation may sign the Illinois Department of Public Aid claim form with the attending physician's name appearing on the claim form.

Adopted, in amended form, a resolution that ISMS encourage county medical societies to establish medical review committees, including utilization review in long-term care institutions.

Adopted a resolution suggesting liaison between medical societies and hospital boards of directors by recommending to the AMA House that a publication such as the *American Medical News* be sent to each hospital board member, and that hospital staffs be encouraged to purchase individual subscriptions for hospital board members.

Adopted a resolution calling for ISMS, other societies in the Chicago area, and the AMA, to establish and operate a facility in the City of Chicago to provide medical services to disadvantaged and minority groups.

Rejected a resolution calling for updating the ISMS "Relative Value Study," preferring to rely on usual, customary and reasonable fee definitions as the acceptable method of adjudicating fees.

V. REFERENCE COMMITTEE ON PUBLIC RELATIONS & MISCELLANEOUS BUSINESS

The report of the Council on Public Relations and Membership Services, including a report on the Physician Placement Service, was accepted. Reports of the Committee on Medicine and Religion and the Task Force on Physician Shortage and Services to Medically Deprived Areas, were likewise accepted.

In accepting the report of the Committee on Insurance, it was noted that over 1,100 physicians are now insured under the professional liability insurance program.

PUBLIC RELATIONS PROGRAMS

The House endorsed the Reference Committee's citation for excellence of the public relations programs on rising health costs and the ISMS response to the Senate Finance Committee report on Medicare and Medicaid. The recommendation that consideration be given to increasing the Public Relations Division staff, if increased public relations services are required by the membership, was approved.

A resolution requesting that ISMS document cases in Illinois of residents unable to obtain proper health care, and then propose a solution for the problem, was rejected.

A resolution criticizing the ISMS public relations program for failure to project the viewpoint of the private practicing physician and a request for reorganization of the public relations program was also rejected.

MEDICARE, MEDICAID AUDIT AND PUBLICATION OF FACTS

A substitute resolution was adopted in lieu of two separate resolutions calling for an audit of the administrative costs and expenditures under the Medicare and Medicaid programs and a public information campaign initiated, based upon these findings. The adopted substitute resolution recognized that a distorted picture exists as to the adequacy of health care in the United States,

the reasons behind the expense and short-comings of the Medicare-Medicaid programs and called for ISMS to continue to publicize the physician's share of the health care dollar received under the Medicare and Medicaid programs.

PRIVATE MEDICAL CARE VERSUS GOVERNMENT CARE

A substitute resolution was adopted to replace one calling upon the ISMS to urge AMA to develop a program to promote the present medical care system, including a "Truth Squad" to shadow HEW and to correct improper and incorrect statements in the news media. The substitute resolution expressed criticism of the AMA for failure to convey the positive aspects of private medical care to the public, castigated those who propose compulsory national health insurance and a complete change in the system of health care delivery and called upon the ISMS to urge the AMA to further amplify its efforts in promoting the private practice of medicine. The program to be developed should be directed to both the public and to physicians.

In other actions, the House of Delegates:

Approved implementation of a study of the important relationships between medicine and religion and seminars to be held in various areas in Illinois during 1970 under auspices of the ISMS Committee on Medicine and Religion.

Affirmed the right of the public to protection from unwarranted medical statements appearing in the news media or made by those in government who have misrepresented facts without concern for the health or welfare of human beings—the ISMS Public Relations program to inform the people of Illinois of this policy—the delegates to the AMA to introduce this principle into the AMA House of Delegates.

Adopted a substitute resolution approving the concept of a National Academy of the Health Professions—that the study of the delivery and cost of health care, subsequently followed by appropriate planning, be the primary concern of the Academy—that detailed reports be made to the

AMA House of Delegates at appropriate intervals.

Rejected a resolution which referred to the Himmler Report and pertained to the wasteful use of manpower and the method for electing directors to the proposed National Academy of Health Professions.

VI. REFERENCE COMMITTEE ON LEGISLATION & PUBLIC AFFAIRS

Reports of the Council on Legislation and Public Affairs, Committee on Public Affairs, Task Force on Comprehensive Health Planning, Eye Health Committee, Impartial Medical Testimony Committee, Laboratory Services Committee and the Committee on Licensure, were accepted.

The initial report of the Medical Legal Council was accepted but that portion of the supplementary report dealing with limits on nurses services in nursing homes, was referred back to the Medical Legal Council for further study and clarification.

PHYSICIAN LICENSURE

The Reference Committee's recommendation that the major problem with respect to licensure appears to be a lack of communication between the applicants and the Medical Examining Committee, was accepted. Three of the four resolutions, dealing with examining procedures under reciprocity were referred to the Medical Legal Council and its Committee on Licensure for further study. An additional resolution calling upon the ISMS to use its resources in seeking to have the Board of Medical Examiners process applications for medical licensure by reciprocity or endorsement on at least a monthly basis when such applications are pending, was adopted.

LICENSING OF MENTAL HOSPITALS

A resolution was adopted which calls for the ISMS to seek changes in legislation or administrative regulations to provide for licensing of mental health facilities. The action calls for:

"Those services of the Illinois Department of Mental Health which correspond to services offered by private psychiatric hospitals, general hospital psychiatric units and sheltered care facilities be subject to the same minimum standards (sic—as other hospitals), so that appropriate parts of all health care facilities in the state can be licensed by the Department of Public Health."

AD HOC REFERENCE COMMITTEE

A special ad hoc reference committee was appointed to hear medical student views concerning student unrest, campus violence, the war in Indochina and the needs of the medically disadvantaged.

The House agreed with the views of the Reference Committee in recognizing the mood of helplessness that enveloped the SAMA at the recent convention due to the problems at Kent State, Jackson, Mississippi and in Cambodia; that our national priorities need rearrangement and that physicians become involved and accept the challenge to be both healer and citizen.

The House also agreed with the Reference Committee that the free exchange of ideas between members of the Society and the students provided a refreshing segment

An amended resolution was adopted regarding increase in tuition fees to the University of Illinois students. The substitute resolution provides that the ISMS, through its Division on Legislation and Public Affairs work during the upcoming session of the state legislature to lower the tuition structure as recommended by the Governor.

PUBLIC AFFAIRS—AMPAC

The House adopted an amended resolution relative to the 1971 AMA/AMPAC Workshop held in Washington, D.C. The amended resolution provides for the ISMS delegation to introduce a resolution at the AMA House of Delegates requesting that this meeting be changed to the broad type of public affairs conference conducted annually by the Chamber of Commerce of the United States. It further provides that the conference be held in the early part of the week to permit visitation with senators and congressmen in Washington, that the program be attractive to the general medical society membership and that the program be publicized in advance of the event.

A resolution was adopted directing the ISMS delegates to the AMA House of Delegates to submit a resolution requesting the formation of a council or committee on public affairs within the AMA structure.

ACTION WITHOUT REFERENCE—COOK COUNTY HOSPITAL

The House adopted a resolution, without reference to committee, recommending the creation of a Committee to be composed of two members appointed by the Governor, two members appointed by the Mayor of Chicago and a fifth member, agreeable to both, who would serve as chairman, to serve impartially in resolving the controversies and to seek avenues of agreement between the Hospital Governing Commission and the Cook County Board of Commissioners in order that the Cook County Hospital may remain in full operation.

of the Annual Meeting, although polarity was present on some of the issues. The House also agreed with the recommendation that such an opportunity for student and physician colleagues to have meaningful dialogue of broad issues of concern, be a regular feature of future annual meetings.

In acting upon a resolution submitted on behalf of the students' viewpoint on the war in southeast Asia, the House adopted a substitute resolution. The substitute resolution provided that the "ISMS exhort the administration of the United States to continue with all due speed its present policy of intent with respect to humanitarian principles."

VII. REFERENCE COMMITTEE ON EDUCATION & COMMUNITY HEALTH SERVICES

The House reviewed and accepted the reports submitted by the Council on Education and Manpower, the Committee on Scientific Assembly, the Council on Environmental and Community Health, Advisory Committee to SAMA, the Council on Mental Health and Addiction, the Committee on Narcotics and the Committee on Alcoholism.

Communications from the Director of the Illinois Department of Public Health and the acting Director of the Illinois Department of Mental Health were received as information.

CONTINUING EDUCATION

The report of the Committee on Continuing Education was accepted including two recommendations:

"What Goes On" should be revived, if adequate financing can be obtained; and

The Committee on Scientific Assembly should institute refresher courses for credit during the 1971 annual meeting.

Endorsement, in principle, was given to a continuing education program under development by the University of Illinois.

SPEAKERS BUREAU

The House expressed its appreciation of Merck, Sharp and Dohme for continued financial support of the ISMS Scientific Speakers' Bureau which provides scientific programs for county medical society meetings.

PHYSICIANS' ASSISTANTS

The reports of the new Committee on Allied Health Education were approved. The House gave encouragement to the Committee to proceed with its plans to develop new categories of physician assistants, including the use of discharged military corpsmen and premedical students unable to find medical school openings. Also the development of an open-ended educational system which would allow assistants eventually to become physicians.

The House recommended that more practicing physicians be appointed to the Allied Health Committee.

ADMISSION POLICIES OF U OF I

The report of the Student Loan Fund Committee was approved with the recommendation that the University of Illinois be asked to develop admission policies and tutorial services that will give the same consideration to borderline scholars from medically deprived areas as it is now extending to students from the inner city.

LOANS TO OSTEOPATHIC STUDENTS

A resolution was approved endorsing the action of the Student Loan Fund Board to include osteopathic students under the loan program.

LOAN PROGRAM FOR INNER CITY

The House adopted a resolution calling upon the ISMS to appropriate monies from the Task Force on Physician Shortage and Services to Medically Deprived Areas to establish a loan program for the inner city, similar to the present loan program for rural students.

SPECIAL ASSESSMENT

By special assessment of \$2 per dues paying member for one year, the Illinois Medical Journal and PULSE are to be mailed to SAMA members of Illinois chapters.

NOTE: As an assessment, this amount is not deductible for income tax purposes, as are dues.

LIAISON WITH RESIDENTS AND INTERNS

The Advisory Committee to SAMA was instructed to develop and implement a plan of liaison with interns and residents through house staff organization.

NO LEGALIZATION OF MARIJUANA

The House approved the Child Health Committee recommendation that the ISMS oppose any legislation to legalize marijuana. Illinois physicians were encouraged to distribute drug abuse literature through their offices and in schools and be present for discussions, if possible, when drug abuse films are shown in the community.

WELFARE FOOD ALLOWANCES

In approving the report of the Nutrition Committee, the House adopted six recommendations regarding the IDPA food allowances:

1. The IDPA food allowance should be increased to conform with the USDA Low Cost Plan.
2. Every effort should be made to expand and implement all supplementary food programs in Illinois including the food stamp program, the school lunch program and the supplementary foods program.
3. Food allowances should be adjusted in the future for increases in the Bureau of Labor Statistics Price Index with reevaluations every 3 months and budgeting increases fully commensurate with the increase in the costs of living.
4. Other items of the IDPA budget should be revised and repriced regularly to make them current and decrease pressure on the food budget.
5. Consumer education should be further implemented and expanded by the most efficient media or method available.
6. Clearing house for nutrition information should be established at a state level with the responsibility of accumulating and disseminating professional nutrition materials and data.

SHORTER RESIDENCIES

The House endorsed a resolution requesting the AMA House to condemn Specialty Boards for lengthening training requirements and thus removing additional physicians from the practice of medicine.

SCHOOL HEALTH EXAMINATIONS

A policy was adopted which requires that the ISMS urge all school districts to provide funds in the budget to employ sufficient doctors and other health professionals to carry out school health procedures as required by law.

NOTE: Present policy on examinations reads as follows:

All physical examinations should be performed in the physician's office. No examinations should be conducted on a group basis unless authorization has been given by the local county medical society in a single instance or for a specific purpose.

This general statement does not apply to the industrial or occupational health physician in his in-patient activities.

An amended resolution was adopted providing that all

physical examinations of children entering kindergarten, fifth and ninth grades may be done within one month of the child's appropriate birthday, commensurate with the corresponding grade level. The resolution is to be forwarded to the State Superintendent of Public Instruction as the basis for altering the Illinois School Code.

PHYSICAL STANDARDS FOR DRIVERS

An amended resolution was adopted which directs the Committee on Public Safety to prepare a compendium of recommended minimum physical standards for evaluating drivers of specific vehicles, to be submitted at the next annual meeting for approval and subsequent publication.

In further action the House:

Approved the removal of age restrictions on training programs and employment in health occupations under the Illinois State Radiation Protection Act.

Put ISMS on record in favor of state income tax sharing directly with school districts, to completely subsidize school lunch programs.

Adopted a recommendation that the Illinois Health Department employ a full time consultant in Obstetrics and Gynecology.

Approved the recommendation that sex education be a part of the medical school curriculum.

Rejected a resolution suggesting that young physicians, as an alternative to military service, be allowed to practice in those areas where physician shortages are critical and that equal time, pay and privileges be extended to physicians serving in either the armed forces, or in areas of medical need.

Referred to the Allied Health Education Committee a resolution requesting ISMS to contribute \$10,000 for 1970-1971 to the Council for Bio-Medical Careers, to develop more interest in health careers among inner city students.

Adopted an amended resolution asking ISMS to take every appropriate action possible to assist in preventing irreversible health hazards due to the pollution of Lake Michigan.

Adopted as amended a resolution calling for ISMS to request the Department of HEW to delete a sentence from the oral contraceptive package insert, which in effect stated that *all* side effects were to be discussed between patient and doctor, a policy deemed unwise by the House.

Rejected a resolution on increasing the number of medical students in Illinois on the grounds that the Society's program is already working in this direction.

ACTIONS ON RESOLUTIONS 1970 HOUSE OF DELEGATES

Number	Introduced by:	Title	Action
70M-1	Rock Island Co.	Processing of Licensure by Reciprocity	Adopted
70M-2	Rock Island Co.	Elimination of Reciprocity Examinations	Referred to Medical Legal Council
70M-3	DuPage County	Third party carriers & payment of fees	Adopted
70M-4	Madison County	Documentation of need for health care in Illinois	NOT adopted
70M-5	Madison County	Reorganization of PR Program	NOT adopted
70M-6	Madison County	Audit of Medicare/Medicaid & IPAC (IDPA)	Considered with #8, Substitute Resolution adopted
70M-7	Madison County	Promotion of present system of medical care	Substitute resolution adopted
70M-8	Madison County	Audit of Medicare/Medicaid for info. of the public	Considered with #6, Substitute resolution adopted
70M-9	Madison County	School health examinations	Adopted as amended
70M-10	Board of Trustees	AMA-ERF Unassigned Funds	Adopted as amended
70M-11	Fredric Lake	Affiliate status for Ill. Chapter American College of Radiology	Referred to Board of Trustees
70M-12	Anna Marcus, for Com. on Medicine & Religion	Seminars on Medicine & Religion	Adopted as amended
70M-13	Livingston County	Elimination of Drug Manual	NOT adopted
70M-14	Livingston County	Physical standards for drivers	Adopted as amended
70M-15	Frank J. Jirka, Jr., for Board of Trustees	Ad Hoc Status for Comm. on Committees	Adopted as amended
70M-16	Frank J. Jirka, Jr., for Board of Trustees	Permission for AMA delegates to serve on Councils & Committees	Adopted
70M-17	Kane County	Protection of the Public from Unwarranted medical statements	Substitute resolution adopted
70M-18	LaSalle County	Use of Peer Review mechanism	NOT adopted
70M-19	Will-Grundy County	Restriction of occupational exposure of minors	Adopted as amended
70M-20	Will-Grundy County	School Lunch programs	Adopted
70M-21	Will-Grundy County	Third Party Claim forms	NOT adopted

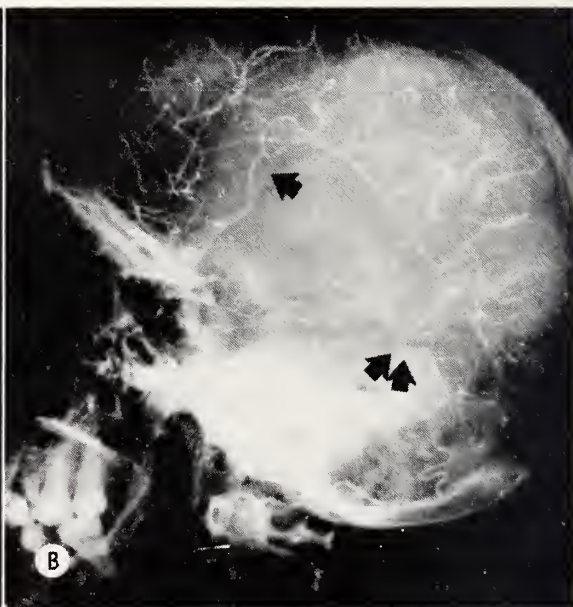
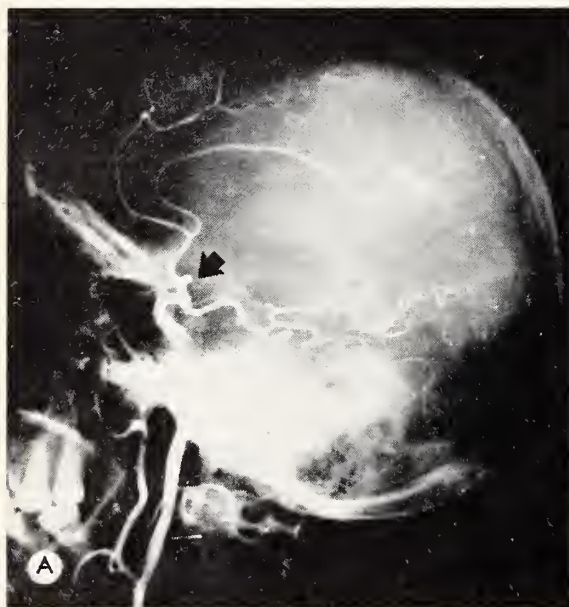
<u>Number</u>	<u>Introduced by:</u>	<u>Title</u>	<u>Action</u>
70M-22	Will-Grundy County	Residency training periods	Adopted
70M-23	Will-Grundy County	Dept. of Public Aid Claim forms—Procedure	Adopted as amended
70M-24	Will-Grundy County	Long Term Institutional care	Adopted as amended
70M-25	Will-Grundy County	Ill. Medical Society Reserve Funds	NOT adopted
70M-26	Will-Grundy County	Powers of House of Delegates under Constitution & Bylaws	Referred to Board of Trustees
70M-27	Will-Grundy County	Powers of House of Delegates under Constitution & Bylaws	Referred to Board of Trustees
70M-28	Will-Grundy County	Dues Increase	NOT adopted
70M-29	W. Plassman, for Com. on Mental Health	Professional Licensing Policies	Referred to Medical-Legal Council
70M-30	W. Plassman, for Com. on Mental Health	Licensing of State Mental Health Facilities	Adopted
70M-31	Lake County	Liaison with Hospital Boards	Adopted
70M-32	Lake County	Pagination Policy of JAMA	Adopted as amended
70M-33	E. W. Cannady, for AMA Delegation	Approval of National Academy of the Health Professions	Substitute resolution adopted
70M-34	J. E. Reisch, for Commission on Physicians' Liability	Malpractice	Substitute resolution adopted
70M-35	E. K. DuVivier	Distribution of AMA-ERF unassigned Funds	NOT adopted
70M-36	Jack Gibbs, for Student Loan Comm.	Inclusion of Osteopathic Students in Loan Fund Program	Adopted
70M-37	Jack Gibbs, for Council on Education	Opposition to tuition increase at University of Illinois	Adopted as amended
70M-38	DuPage County	Nursing Service relationships with Medicare	NOT adopted
70M-39	DuPage County	Financial support of County Society Peer Review Committees	Approved in principle
70M-40	A. J. Faber, for Public Affairs Committee	AMA/AMPAC Workshop in Washington	Adopted as amended
70M-41	J. Ovitz, for Public Affairs Committee	AMA Physician's Public Affairs Council	Adopted
70M-42	Fulton County	Himler Report—Manpower & Composition of National Academy	NOT adopted
70M-43	Fulton County	Himler Report—Resolution of serv. in urban & rural areas as alternative to military service	NOT adopted
70M-44	Alfred Klinger	Loan Program for Inner City students	Adopted
70M-45	Alfred Klinger	\$10,000 contribution for Council on Bio-Medical Careers	Referred to Allied Health Education
70M-46	Winnebago County	Increased Frequency for Reciprocity Examinations	Referred to Medical-Legal Council
70M-47	Allison Burdick, for Health Organization to Preserve Environ.	Pollution of Lake Michigan	Adopted as amended
70M-48	Will-Grundy	Current procedural terminology & relative value study	NOT adopted
70M-49	Herschel Browns	Cessation of Hostilities in S.E. Asia	Substitute resolution adopted
70M-50	Board of Trustees	Hospital Reimbursement	Adopted as amended
70M-51	Chicago Medical Society	Med. Services for disadvantaged & Minority Groups	Adopted
70M-52	Robert. R. Hartman	Oral Contraceptive Pkg. Insert	Adopted as amended
70M-53	DuPage County	County Society Peer Review Comm. as 1st appellate body	Adopted
70M-54	E. Lowenstein, for 9th District, ISMS	Increasing number of practicing physicians in Illinois	NOT adopted
70M-55	G. Tomlinson	Cook County Hospital Controversy.	Adopted without referral



THE VIEW BOX

BY LEON LOVE, M.D.

*Director, Department of Radiology, Loyola University Hospital
and Chairman, Department of Radiology, Loyola University
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This 60-year-old patient entered the hospital following a sudden occurrence of hemiplegia on the left side associated with sudden loss of consciousness and an aphasia. The patient was studied arteriographically one week later at which time she was showing evidence of recovery. A left carotid arteriogram was done (Fig. 1A, 1B, 1C). What's your diagnosis?

(Answer on page 92.)

Hypnotic effect of Methaqualone

Employing placebo responder elimination

BY ARPAD ALMASSY, M.D./CHICAGO

Among the problems associated with typical double blind evaluations of hypnotics are the need for large numbers of patients and the often reported lack of discrimination between doses of soporific drugs commonly employed in clinical practice and placebo controls. Hinton has reported that 100 mg. doses of butobarbital, quinalbarbital and amylobarbitol were "in most cases insufficient to produce a significant difference from placebo" in the patients studied. Lasagna has suggested that "placebo reactors" may mask real differences between drugs by their failure to discriminate between potent and non-potent drugs.

Arpad Almassy, M.D., is on the attending staff at Chicago State Tuberculosis Hospital and Roseland Community Hospital, Chicago, Illinois. He received his M.D. from the University of Cluj in Hungary, and served his internship and residency at Cluj. Dr. Almassy was a Board-Certified Internist in Budapest (1948), and received Illinois licensure in 1959. He is a member of the American Thoracic Society.



Clinical efficacy of methaqualone, a non-barbiturate hypnotic with an extensive history of clinical usefulness in the management of insomnia, has been reported by Parsons and Thomson,¹ Barcello² and Sapienza.³ In each of these studies, clinical response to methaqualone was compared with responses to a barbiturate and a placebo. Although in each instance these investigators were able to confirm the hypnotic efficacy of methaqualone, they did not find differences between methaqualone and barbiturates which might be anticipated on the basis of prior uncontrolled observations, Yaginuma,⁴ Arvers,⁵ and Ravina.⁶

Since Lasagna⁷ has indicated that responsiveness to placebo may decrease sensitivity of clinical studies and thus obscure real differences between drugs, we attempted to devise a means by which the incidence of placebo reactors might be reduced.⁸ This procedure, previously reported, was employed in conjunction with a clinical comparison of methaqualone,* pentobarbital and placebo in patients suffering from insomnia.

*SOPOR®, Arnar-Stone Laboratories, Inc.

Materials and Methods

Forty-eight male patients, who had been hospitalized for the treatment of chronic respiratory disorders, were selected for study. The age range was from 27 to 87 years. Debilitated patients, as well as those with severe disorders of liver or kidney function, were excluded. Similarly, patients who described only moderate difficulty in getting to sleep and only occasional periods of wakefulness during the night were not included.

Only patients with moderate insomnia (sleeplessness every night with difficulty in getting to sleep, and two or three periods of wakefulness every night) and severe insomnia (defined as an inability to obtain a satisfactory night's sleep without the use of hypnotics) were selected for study.

In 13 patients the history of insomnia began with the date of hospitalization. In the entire series the history of insomnia ranged in duration from several days to several years. Only 15 patients had never received hypnotic medications in the past. Barbiturates had been most commonly employed (23 patients).

During the first phase (Phase I) of the present study, in an attempt to eliminate the placebo reactors, all 48 patients received a placebo capsule (SULE,[®] Arnar-Stone Laboratories), containing sucrose and cornstarch, at bedtime. Phase I was not double-blind, and the patients were told that the capsules were intended to help them sleep. The placebo capsule produced a satisfactory response, which was sustained for a period of 14 days, in 13 patients. These patients were classified as placebo reactors and dropped from the study group. Eight others were also eliminated from the study, for a variety of reasons, *i.e.*, refused to accept medication, during Phase I. The remaining 27 patients, who had not shown an adequate or persistent responsiveness to the placebo capsule, were then transferred to the second phase (Phase II) of the study.

For the second, double-blind, phase of the study all medications were dispensed as compressed yellow tablets containing 150 mg. of methaqualone, 100 mg. of pentobarbital sodium, or inert ingredients. The assignment of patients was by means of a series of random numbers, and medications were dispensed by personnel not involved in the evaluation of the response. Thus,

neither the patient nor the physician knew the identity of the drug used in a given patient. At the conclusion of Phase II, it was found that ten patients had been receiving methaqualone, nine patients had been on pentobarbital sodium, and eight had been receiving the placebo (as they had during Phase I).

Results

The overall response to therapy was evaluated each morning for each patient. The criteria included ease of falling asleep, frequency of awakening during the night, and the presence or absence of "hangover" or other side effects. All data were collected

Table 1.

The Overall Response to Therapy

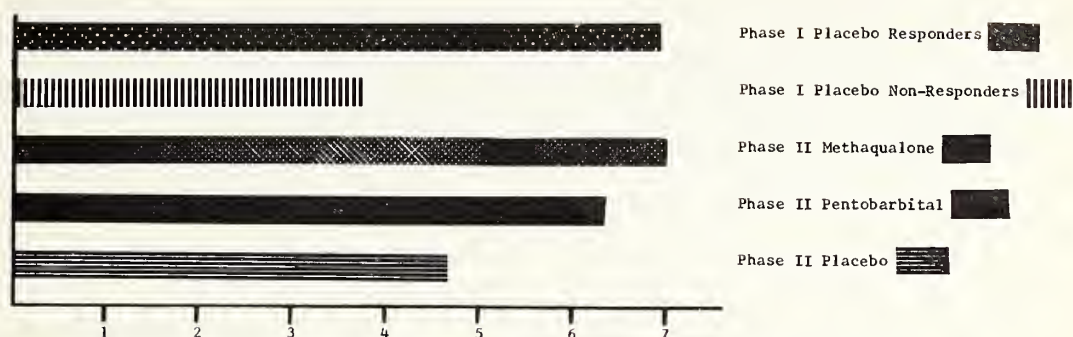
Drug	No. of Patients	No. of Nights Evaluated	Excellent	Good	Fair	Poor
Phase I*	13	162	56	92	13	1
Phase II						
Methaqualone	10	123	35	73	13	2
Pentobarbital	9	96	26	36	14	20
Placebo	8	78	12	37	22	7

*Single-blind phase—placebo reactors.

daily by the ward physician personally, and correlated with the nurses' notes. An additional parameter, based on an objective evaluation of the duration of sleep was also measured, as described below. This evaluation yielded the following results:

It should be emphasized that the 13 Phase I patients were "placebo responders" who were not subsequently transferred to the double-blind second phase. The percentage of patients showing an excellent response on methaqualone and pentobarbital (28% and 27% respectively) was essentially identical and approximately twice as great as that on the placebo (15%). A difference between methaqualone and pentobarbital became more evident when the percentage of excellent and good responses were combined. Thus, the percentage of excellent-good responses on methaqualone was 88; compared with 65 on pentobarbital, and 62 on the placebo. It should also be noted that the percentage of poor responses was greatest in patients receiving pentobarbital.

In addition to the qualitative assessment of the response summarized above, an objective semi-quantitative evaluation based on the duration of sleep was also performed. The elapsed time between the onset of



sleep and time of awakening was adjusted by subtraction of the duration of periods of wakefulness during the night. If a period of wakefulness was less than 30 minutes, or if the duration could not be determined, 30 minutes was arbitrarily subtracted (Zaroslinski, et al).⁸

During Phase I (in the 13 placebo responders) the average adjusted sleep score was 6.9 ± 0.15 hours. In those patients who were not responsive to the placebo in Phase I (the 27 patients subsequently transferred to Phase II), the average adjusted sleep score was 3.7 ± 0.19 hours. During Phase II the adjusted sleep score on methaqualone was 7.0 ± 0.28 hours; on pentobarbital it was 6.2 ± 0.45 hours; and on the placebo it was 4.8 ± 0.78 hours. These average adjusted sleep scores may be compared graphically as in Figure 1.

The average adjusted sleep scores for methaqualone, pentobarbital, and placebo were compared using Fisher's Analysis of Variance Techniques (Batson).⁹ Preliminary analysis of variance clearly established that the scores differed significantly ($P < 0.01$). The alternate analysis of variance test was then employed to determine differences between the individual groups. Examination of the result data showed that methaqualone was significantly more effective ($P < 0.05$) than both pentobarbital and placebo.

The response to methaqualone was significantly superior to that induced by pentobarbital or placebo. There were no serious side effects reported for any of the medications during the course of this study. Occasional patients complained of minor effects such as drowsiness, etc., but were too few in number to permit a meaningful statistical analysis.

Discussion

Selection of patients for a clinical study usually presents problems in regard to the suitability of particular subjects. Ostensibly, careful observation and case history should serve to facilitate such selection. However, our results suggest that full reliance on these procedures may result in the inclusion of some subjects who are not fully suitable as clinical material. Pre-screening with respect to placebo responsiveness would appear to be worthwhile.

It is of interest that the response to methaqualone was significantly superior to that of pentobarbital both qualitatively and quantitatively. This is in contrast to results reported by Parsons,¹ Barcello,² and Sapienza.³ These authors found no significant difference between effects obtained with methaqualone and cyclobarbital, secobarbital, and pentobarbital, respectively. The subjective excellent-good-poor grading of patient response has been widely employed by clinical investigation and may be responsible for failure to exhibit differences between hypnotics, or hypnotics and placebo, in the usual clinical dosages. Objective data is preferable, and the patient's response should be the valid goal of such a study. We believe that the addition of the semi-quantitative evaluation introduced here enhances the validity of the study and increases the degree of discrimination.

The preliminary elimination of placebo responders, 32.5% of the population, may account for this difference. The omission of placebo responders appeared to make the population being tested more homogeneous and decrease extraneous variables. Deletion of placebo responders appeared to increase the sensitivity of the clinical test procedure

by providing a more valid insomnia population. Thus, the drug response is being tested against the specific complaint and the final results are not being diluted by patients which normally respond to placebo therapy. However, insomnia is self-limiting and a degree of placebo response can occur even after preliminary elimination of definite placebo responders.

The importance of the "placebo reactor" in the evaluation of drugs has been described by Lasagna,⁷ Batterman^{10,11} and Zaroslinski, et al.⁸ Since there is an important psychosomatic element in insomnia, comparisons of hypnotic drugs should include elements designed to reduce the impact of the placebo responder insofar as this is possible. We believe that this was largely accomplished in the present study by its division into phases, the first of which was solely designed to eliminate placebo responders.

Because of the additional control element provided by the first phase of our study, it is our opinion that the validity of our results is enhanced and a more accurate determination is possible with fewer patients. These results indicate that a dose of 150 mg., methaqualone is a highly effective hypnotic. Methaqualone was found to produce a statistically significant increase in the adjusted average duration of sleep when compared to pentobarbital and placebo. This value of the duration of sleep was valid both qualitatively and quantitatively.

Summary

Forty-eight male patients, who had been hospitalized with various chronic respiratory diseases, were selected for a double-blind, placebo-controlled evaluation of methaqualone and pentobarbital sodium in the management of insomnia. The study was divided into two phases. During the first phase, all patients were given a pellet-containing, placebo capsule. During this phase, which was not double-blind, eight patients were dropped from the study group for various reasons. Twenty-seven others were taken off the placebo within 14 days because it failed to induce a persistently

adequate response. These patients subsequently entered the second phase of the study. Finally, there were 13 patients who responded consistently to the placebo, and when this responsiveness was found to continue for a period of 14 days, they were removed from further consideration as "placebo reactors."

During the second phase of the study, ten patients received methaqualone (150 mg. at bedtime), nine were given pentobarbital sodium (100 mg. at bedtime), and eight received the placebo. Both medications and the placebo were in the form of compressed, yellow tablets, and this phase of the study was double-blind. In addition to subjective observation recorded by trained medical observers, a semi-quantitative parameter of adjusted sleep duration was evaluated.

The percentage of excellent and good responses on methaqualone (88) was greater than that on pentobarbital (65) or placebo (62). The adjusted average duration of sleep on methaqualone (7.0 hours) was greater than that of pentobarbital and placebo to a statistically significant degree.

References

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Little Facts About Big Government

The U. S. Department of Agriculture spent five years revising pickle standards in order to describe the difference between curved and crooked pickles.

SOCIO ECONOMIC *news*

A service of the Public Relations and Economics Division

BY JOSEPH J. LOTHARIUS

"Foundations for Medical Care" Considered

ISMS Trustees are seriously considering the pros and cons of the "Foundation for Medical Care" concept. FMC's are presently active in several California counties and their popularity is beginning to spread eastward. An FMC is an organization of physicians, sponsored by a local medical society, who are concerned with the development and delivery of medical services and the reasonable cost of health care, whether privately or publicly financed.

The FMC concept includes free choice of a personal physician, the fee for service concept, and local control through peer review mechanisms. FMC's can set up minimum health care standards and offer broad coverage within a reasonable cost level. Quality care is emphasized through utilization review techniques by both physician and patient. Is the FMC concept the "wave of the future"—and the answer to a national health insurance system?

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Black Ink "A Must" On Vital Records

All Illinois physicians, funeral directors, coroners and hospital administrators were urged to start using black ink when filling out vital records which will be reproduced. The request was made by Dr. Franklin D. Yoder, director of the Illinois Department of Public Health. Dr. Yoder announced that beginning January 1, 1971, his Department would instruct local registrars and county clerks to accept for filing **ONLY** those certificates filled out in black ink. He said in order to insure clear, sharp certified copies from either a photocopy or from microfilm, the original certificate must be prepared in clean, black typewriter ribbon or black ink.

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ISMS Members Support Public Health Programs

A recent ISMS survey of county medical societies revealed nearly 2,500 physicians gave more than 12,500 free man-hours of time worth an estimated \$660,000 to public health programs during the past year. Over 800,000 children benefited from free inoculations or screening programs during the 12-month period ending May 15. Inoculation programs included rubella, measles, diphtheria, smallpox and polio. Screening projects included pre-school visual exams, hearing and vision tests, physical examinations, tuberculosis and diabetes testing. These statistics are very conservative because less than 25 per cent of the state's county societies responded to the survey.

Be EXACT On Your Medicare Claim Form

Physicians treating Medicare patients should make certain their patient's name listed on the 1490 claim form is an EXACT duplicate of the name appearing on the patient's health insurance card. According to Continental Casualty Co., Part B Medicare carrier for much of Illinois, any difference, however slight, could delay your claim as much as 90 days. Continental reported that all Medicare eligibility records are maintained in Baltimore by the Social Security Administration and computerized techniques in checking records require the exact information.

RE: Third Parties And Fees

ISMS Delegates reaffirmed three basic principles during the convention regarding third party carriers and payment of fees. These are: 1) Unless a physician accepts assignment as payment in full, the patient, not the third-party, is responsible for payment of medical fees; 2) a patient should be reimbursed by his insurance carrier for necessary consultation fees; and 3) a physician's usual and customary fees should be accepted as such by the carrier, with contractual reimbursement made to the patient, with the carrier implying any "overcharge."

Film Reviews

The nature of cystic fibrosis, its genetic transmission, procedures for diagnosis and treatment are explored in "Diagnosis and Management of Cystic Fibrosis," a 16mm, sound, color film. The film refers to research attempting to establish the etiology of cystic fibrosis and to pinpoint the underlying biochemical defect which results in the secretion of abnormal sweat, saliva, and mucus. Also discussed in the film are diet, exercise, the role of the parents in home care, surgical complications and child-bearing by young women affected with the disease. Contact for free short-term loan: National Medical Audiovisual Center (Annex), Station K, Atlanta, Georgia 30324, Attn: Film Distribution.

"A Matter of Opportunity," a 16mm, 27 minute film explores the situations faced by black students as they pursue careers in the field of medicine. The need for black physicians, black paramedical people, black midwives, and black nurses is also discussed in the film, available on loan to medical societies from the AMA Film Library, 535 North Dearborn Street, Chicago 60610.

"Intestinal Amebiasis" and "Extraintestinal Amebiasis" are two of the 16mm films in the clinical pathology series. Illustrations include drawings and photographs of the parasite, typical and atypical ulcers, and preparation of wet mounts. The aspects of extraintestinal amebiasis, including hepatic abscess and cutaneous complications are dealt with in the second film. Contact for free short-term loan: National Medical Audiovisual Center (Annex), Station K, Atlanta, Georgia 30324.

"Current Trends in the Therapy for Narcotic Addiction," a 16mm, 29 minute film features Dr. Daniel H. Casriel, medical psychiatric superintendent of Daytop Village, a therapeutic community for addicts, and Dr. Jerome H. Jaffe, director of the Drug Abuse Program in Illinois. Dr. Casriel views narcotic addiction as "withdrawal behind a chemical as a response to stress." Dr. Jaffe questions the psychiatric approach and discusses the methadone treatment of addicts in Chicago. Contact: National Medical Audiovisual Center (Annex), Station K, Atlanta, Georgia 30324, for free, short-term loan.

Rx Products

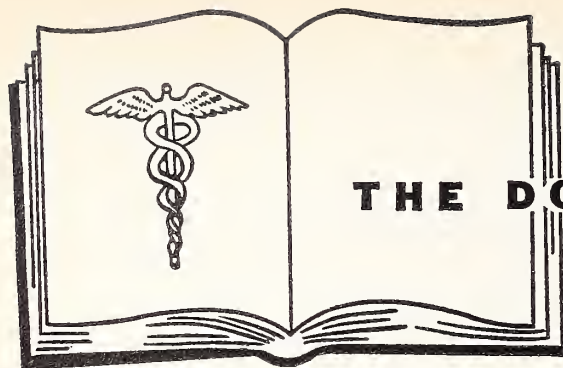
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Use of Methadone

The potential motivation of criminal addicts for methadone treatment was tested in the New York City Correctional Institute for Men. Of 165 inmates seen, all with records of five or more jail sentences, 116 (70 per cent) applied for treatment after a single interview. None of them had previously made application to the methadone program.

Of 18 randomly selected from all applicants with release dates between January 1 and April 30, 1968, 12 were started on methadone before they left jail and then referred to the program for aftercare. None of them became readdicted to heroin, and nine of 12 had no further convictions during the 50 weeks of follow-up study. All of an untreated control group became readdicted after release from jail, and 15 of 16 were convicted of new crimes during the same follow-up period. (Vincent P. Dole, M.D., J. Waymond Robinson, M.D., John Orraca, Edward Towns, Paul Search and Eric Caine: "Methadone Treatment of Randomly Selected Criminal Addicts." *New England J. Med.* 280:25 [June 19] 1969.)



THE DOCTOR'S LIBRARY

LUNG CANCER: A STUDY OF FIVE THOUSAND MEMORIAL HOSPITAL CASES, Edited by William L. Watson, Published by C. V. Mosby Co., St. Louis, 1968. 454 Illus., incl. 6 color plates, 584 pages. Price: \$29.50.

This review of the 5,000 cases of lung cancer seen at the Memorial Hospital is analyzed to present the natural history of the disease, its diagnosis, treatment, and prognosis. As such it is a valuable contribution to our information on cancer of the lung. Despite multiple authorship, a unified philosophy relative to the management of patients with lung cancer is presented. The trend is more aggressive in all aspects of therapy than is generally utilized by many thoracic surgeons at the present time. Unique in their experience is the use of interstitial implantation of radioactive seeds at the time of thoracotomy when nonresectable disease is found. Sporadic use of this form of treatment has been used by others but the experience at the Memorial Hospital is the most extensive in America. Whether or not greater acceptance of the modality by others based on the good results reported cannot be answered.

The text is well written and the illustrations are of high quality. Numerous chapters, among which are the ones on the radiologic diagnoses, pathology, and cytology, are excellent. Unfortunately, in an attempt to be all inclusive, pleural tumors and benign tumors of the lung are also covered in the text; neither, do I believe, should come under the heading of lung cancer. Likewise, in review of the hormonal manifestations, insulin activity which has been associated with pleural tumors is discussed, which may confuse the unwary.

The text may be recommended to all those interested in lung cancer and should be a ready reference volume.

Thomas W. Shields, M.D.

TODD-SANFORD CLINICAL DIAGNOSIS BY LABORATORY METHODS, Edited by Israel Davidsohn, M.D., F.A.C.P. and John Bernard Henry, M.D., 1,308 pages, W. B. Saunders Company, 1969.

The field of clinical pathology has now grown so large that it is virtually impossible to compress it all into one volume, and it is necessary to concentrate on certain topics of practical interest. In the new edition of this classic text, emphasis has been placed on hematology, microbiology and clinical chemistry. The text has been completely rewritten by many new contributors. New chapters on spectrophotometry, endocrine measurements, amniotic fluid, pregnancy tests, seminal fluid, cytogenetics and laboratory planning serve to round out the text and are successful in bringing it up to date.

The book is increased in size by 288 pages, and in weight by 873 grams, to a total weight of over 3.2 kilograms. This is large enough that it is uncomfortable for bedtime reading. Perhaps the editors will consider printing the next edition in two volumes.

This standard text book is recommended for physicians interested in clinical laboratory diagnosis, medical students and medical technologists. It is a necessary reference book for the practicing pathologist.

Joseph C. Sherrick, M.D.

PREMATURITY AND THE OBSTETRICIAN Denis Cavanagh and M. R. Talisman, Appleton-Century-Crofts, New York, New York April, 1969.

This unique and well-written book deals with premature infants from the obstetric point of view, discussing not only the problems but also the treatment and prevention of prematurity. The view given by the authors is comprehensive, and the team ap-

proach is emphasized as necessary in decreasing premature mortality. Improved antepartum care is stressed. The book is very practical, emphasizing the clinical aspects of the problem. Most of the book is written by Cavanagh and Talisman, but there are special sections written by eight contributors which add to the whole.

The chapters are well-organized, clearly written, and understandable. Charts and graphs are used where necessary and are relevant to the material being demonstrated. A substantial list of references follows each chapter. The chapters covering maternal and fetal factors in premature labor are good, including maternal diet, infections, medications, and anomalies as well as isoimmunization. Surgical procedures in

pregnancy are discussed, and the sections on pharmacology and effects of drugs including analgesia and anesthesia are succinct and worthwhile. The delivery of premature infants is covered thoroughly with emphasis on adequate help being present.

The chapters on resuscitation and care of the premature infant have good illustrations and are concise. They are followed by a good chapter on the pathology of prematurity. The authors conclude the book with methods to decrease the incidence of prematurity through improved medical facilities and care. The book, although written primarily for the obstetrician, will be of interest to pediatricians, pathologists, and anesthesiologists as well.

Paul D. Urnes, M.D.

Trade Name vs. Generic

Tolbutamide has been studied more extensively in this area than other drugs; it can serve as a prototype. In 1963 there were reports in the Canadian literature that patients placed on generic tolbutamide went out of diabetic control. This was restored by returning them to the trade-named product. Some recent studies indicate that minor changes in the amount of inert ingredients, such as disintegrators (in the form of starch or vee-gum), can alter the "available equivalency" even though the chemical equivalency is intact. Increasing the starch from 6 to 7 per cent decreased the disintegration time of the tablets from more than 30 minutes to 2.3 minutes. In normal volunteers an altered tablet with one-half the amount of disintegrator gave blood levels of 1.5 mg. per cent, compared to 7.0 mg. per cent for the routinely-produced, trade-named product. The blood sugar at 90 minutes fell only 2 mg. per cent with the generic product, compared to 14 mg. per cent for the standard item.

Some obvious further steps were undertaken in Canada in 1965. A pharmaceutical analysis of 26 lots from 5 manufacturers was performed which met the Food and Drug Directorate requirements and were considered generically equivalent. The amount of a 500-mg. tablet dissolved in simulated gastric juice at 1 hour ranged from 15.3 mg. to 333 mg., and the tablets disintegrated in from 1 second to 83 seconds. A double-blind study on 25 stable diabetic patients, who had been on the drug for a prolonged period, demonstrated only 1 brand that showed a statistically significant greater effect on fasting blood-sugar levels. They concluded that all of the products tested were satisfactory and that the differences were not of clinical importance. These studies indicate that the differences in tablet formulation did not have significant therapeutic effects and that chemical equivalency was the same as therapeutic. ("Generic Equivalency: Does It Exist?" Maj. Ronald J. Payne, MC, USA. *Medical Annals of the District of Columbia* [Sept.] 1969, pages 490-492.)

In other actions, the Board—

- postponed action on the employment of an additional full-time staff person in the area of health care delivery
- approved continuation of the Usual and Customary Fee Committee as a Committee of the Board
- approved a joint study by the Illinois Pharmaceutical Association, Illinois Veterinary Medical Association and the ISMS of the availability in feed stores of potent drugs not covered by prescription
- approved, in principle, the establishment of the Illinois Registry of Medical Transcribers and referred the details of this proposal to the Council on Medical Service for further study
- acted upon numerous resolutions being submitted to the House of Delegates (see House Abstracts for details)

Board Appointments and Authorizations:

Mr. James Slawny, director, Public Relations and Economics Division, was authorized to attend the 11th Annual Western Conference of the United Foundations for Medical Care at Palm Springs, California on May 21-24, to secure information on the operation of medical foundations.

Appointments to the Ear, Nose & Throat Health Committee were confirmed as follows:

John J. Ballenger, M.D., chairman, Winnetka

George E. Shambaugh, Jr., M.D., Chicago

Paul H. Holinger, M.D., Chicago

Richard E. Marcus, M.D., Skokie

(two additional members from downstate are to be appointed)

Consultants:

Meyer Fox, M.D., Milwaukee, Wisconsin

Earl Hartford, Ph.D., Northwestern University Medical School

Maurice M. Hoeltgen, M.D., Chicago

Recommended Dr. Howard Burkhead, Evanston, for consideration as a member of the Radiation Protection Advisory Council in the Department of Public Health.

The 1970-71, Chairman of the Ethical Relations Committee was authorized to represent the ISMS at the Third National Congress on Medical Ethics, September 19-20, Ambassador Hotel, Chicago.

Approved the appointment of William M. Lees and Frank J. Jirka, Jr., as representatives of the ISMS to the Illinois Association of the Professions.

Big Brother Needs to Diet

"This fiscal year the U.S. Government must pay \$17,000,000,000 in interest on the public debt. In 1941 the total Federal Budget was only \$14,000,000,000. So it is costing Uncle Sam \$3,000,000,000 more to meet his simple interest obligations than it cost him to run the whole works just prior to World War II."—Jenkin Lloyd Jones, president, Chamber of Commerce of the United States.

Leprosy in Ceylon

BY LARRY GREENFIELD, M.D./LOS ANGELES

Leprosy has always struck terror into the hearts of men because of its capriciousness of attack, its mysterious long incubation period, the incidious and inexorable progress of symptoms, and especially because of the ulcers, mutilation, and leonine face in its final stages. In many cultures a person who contracted leprosy was thought to have sinned and therefore been cursed. In primitive countries the disease was assumed to be punishment imposed by the spirits; in India, because the victims or their parents were believed to have sinned, they were given the name of "majarog," curse from the Gods; in China, the victims supposedly were suffering divine punishment for a wrongdoing; and in pre-Christian Persia they were referred to as "the avoided ones."¹ To contract leprosy has always resulted in being labeled an outcast by family, friends and society, and suffering widespread social ostracism.

This dread was perpetuated by the Hebrew word "Zaraath" in the Mosaic Code, and by its erroneous translation as "leprosy"—although in fact it meant any general

scaly condition, whether of human skin, clothing or walls.² The term came to imply religious or medical uncleanness, to be associated with ceremonial exclusion. In Israel today, "Zaraath" still connotes terrible, dread uncleanness. During pandemics of true leprosy in the Middle Ages, the lexical confusion with the Biblical "leprosy" continued to associate the disease with sin and social exclusion.³ With all this historical background, it's not hard to understand the present myths, superstitions, fears and ostracism. Because such attitudes toward leprosy patients still persist in Ceylon they suffer severe socio-economic restrictions.

At one time the term "leper" or its equivalent in another language (e.g. OPO in Nigerian) signified the disease, but by usage it has come to identify the patient. The 5th International Congress for Leprosy 1948, Havana, Cuba, passed a resolution aimed at removing the social stigma from the victims of leprosy: ". . . that the use of the term 'leper' in designation of the patient with leprosy be abandoned and the person suffering from the disease be designated 'leprosy patient'."⁴

Leprosy Patients

Among Ceylon's 12,000,000 people, approximately 4,300 leprosy victims have become all too familiar with the cruel ostracism imposed by centuries of misunderstanding. Prior to 1945, many of these unfortunates would have been sentenced to spend their lives in either Hendala or Bat-



Larry D. Greenfield, M.D., is currently serving his internship at Los Angeles County-University of Southern California Medical Center where he will begin his Internal Medicine Residency. Three months of his fourth year of medical school was spent on the S.S. Hope, Colombo, Ceylon. He received his M.D. from the Chicago Medical School.

ticaloa, Ceylon's Leprosaria, with no hope of ever returning to society. Approximately twenty years later, the 250 new patients found yearly are now treated as outpatients in one of ten clinics.

Hendala, built in 1708, now houses about 850 patients and 12 nurses. The 150 females at the hospital are in a separate walled-off area. The majority of the 700 men in the hospital are Sinhalese; the remaining men, Tamils, are domiciled in one building. Each of the ten wards house 40 to 125 patients. The buildings are little more than walls supporting a thatched roof with no windows or screen doors to restrict the free movement of flies and mosquitoes. Many of the patients are severely deformed. The worst have lost hands or feet; others have severe contractions; some are missing digits, while still others have been blinded by interstitial keratitis or xerophthalmia. Some, to hide their infected sores from the swarming flies, huddle under dirty blankets. Because of extreme shortage of even partially trained personnel, these patients receive little attention to their physical problems. The 700 men must use limited toilet facilities in two malodorous buildings, each of which is equipped with 6 buckets emptied several times a day.

Patients show great ingenuity in devising methods to help pass away the hours at the hospital. A few patients manage a tiny commissary, while others make special padded sandals for their fellow patients. Still others spend time repairing their clothes and helping with the weekly laundry. The remainder play cards, gamble illegally, read outdated newspapers and magazines, or sleep the day away due to boredom. The 150 patients at Batticaloa operate a small dairy which provides a daily supply of milk.

Function of the Physiotherapist

The lone hospital physiotherapist is expected to explain to his charges the attendant complications of their affliction as well as offer the required therapy. He's expected to train patients suffering with peripheral neuropathy, and examine their hands and feet daily for unnoticed thorns, burns or abrasions. He should explain to the patients that pain sensation sensibly limits the strength of normal hand use. However, in the presence of neuropathy, one cannot properly judge the degree of force applied

and it may result in injury. To emphasize the exam's importance, the patient should be told that the avoidance of these everyday hazards will make permanent disfigurement less likely.

The physiotherapist has at his disposal several modalities of therapy which when properly used diminish the likelihood of disfigurement. Oil massages, for example, would help prevent contractures of flexion deformities, and may even help straighten fingers already experiencing contractures. In relieving joint stiffness and increasing circulation to joints in the fingers, molten wax therapy could, if readily available, assist patients in the performance of beneficial active exercises. In the event that these two former modalities do not succeed, the therapist has available splints or casts made of plaster or coconut shell. These should be applied twice weekly in the hope of modifying past orthopedic malalignment, and of preventing any further contractures in the case of infection and lepra reactions. Wax and oil treatments between cast changes could soften dry cracked skin and relieve joint stiffness.

The treatment of ulcers further clutters the physiotherapist's endless schedule. Below are the principles that should be followed:

1. Acute stage with cellulitis: rest, elevation and penicillin.
2. Chronic stage: A shoe molded to take the weight on good skin and hollowed to spare the scar. A soft insole with microcellular rubber is an advantage. In severe ulcers, the sole should be rigid in its entirety and have a rocker.⁵ These past few suggestions are similar to official thoughts explained in a circular issued August 18, 1961, by the Leprosy Campaign Office in Colombo.⁶

Because of the hospital patient load and limited personnel, the full benefits of the therapists are not realized; the outpatient who may not even have access to a therapist receives even fewer benefits.

Socio-Economic Situation

A dole of 20 rupees a month is available to qualified families of hospitalized leprosy victims through Ceylon's Social Service Agency. The infrequent patient who is discharged from the hospital is entitled to a lifetime dole of 50 rupees monthly if he

meets semi-annually with his Leprosy Campaign Officer (similar to our Probation Officer). The officer should examine the patient for infectiousness, try to ascertain if the patient is taking his medications properly, and submit his findings on an official form to the Main Leprosy Campaign Office in Colombo. Many patients ready for discharge refuse to leave the hospital; they know all too well that 50 rupees a month cannot support them, but most significantly, they know the prevailing repressive social attitudes. Most patients are satisfied and content to be housed, fed, and clothed at government expense; albeit, at a level barely above subsistence.

Dr. Paul de Fonseka is almost singularly dedicated to upgrading the socio-economic situation of leprosy patients. He is superintendent of Ceylon's Leprosy Campaign which includes two leprosaria, nine small leprosy clinics throughout Ceylon and the Main Leprosy Clinic at Colombo General Hospital.

The Leprosy Clinic

The main clinic, as a service to patients, is open every day except Poya Day and Pre-Poya afternoon. To avoid the stigma of leprosy, the clinic is designated as a "Special Skin Clinic" or "Room 19." The clinic staff includes a nurse, a bacteriologist who performs skin biopsies, an unlicensed pharmacist and several assistants. Every new clinic patient with the aid of an assistant, completes a "leprosy survey form" that is similar to our history and physical. This survey encompasses the duration of the disease, the social background of the patient and his family, and a list of possible contacts which are of statistical value and importance to the P.H.I. and the Leprosy Campaign Office in leprosy control. Also included is an extensive variety of clinical manifestations of leprosy which are illustrated via symbols on a pair of sketches of the body.

Following this initial work-up, the patient is examined by Dr. Fonseka, who either confirms or disallows the diagnosis. If confirmed, a skin biopsy is done and examined for AFB, medicine is prescribed and dispensed to the patient, and he is given his next clinic appointment. To further avoid the stigma of leprosy and to help the patient retain his position in society, only severely ill patients are sent to

a Leprosaria and then only for the shortest possible time.

Treatment

The suggested course of treatment with DDSD (Diamino-Diphenyl-Sulphone) or Dapsone is described in detail in "Leprosy Campaign Field Circular No. 1/62," written by Dr. Fonseka. The initial dosage of DDS should be 25 mg. q.o.d. for one month, 50 mg. q.o.d. in the second month, and for the third month, 50 mg. q.o.d. for six days with the drug withheld on the seventh day. After these three months, the patient should receive only iron tonics and Vitamin D for two weeks. Subsequently, DDS is to be resumed as in the third month of therapy, for at least two years after the case is declared arrested. The criterion for arrest are:

- "1. By routine methods of examination no bacilli have been found in smears from the skin and nasal mucosa for at least six months, skin examination having been performed periodically from several sites. (monthly)
2. There is no visible infiltration of the lesions, i.e. all lesions have become flat and are not raised either in the center or marginally for at least six months.
3. There has been no alteration in texture, color or size of the lesions, and there has been no erythema for at least six months.
4. No fresh lesions or extension of existing lesions has taken place for a similar period.
5. Anesthesia has remained stationary, i.e. no increase or decrease of cutaneous sensibility during a similar period.
6. No nerve tenderness or pain for a similar period."

Dapsone is not without its varying degrees of side reactions. Mild reactions, such as nausea and vomiting may be alleviated by giving DDS after a meal with sodium bicarbonate. A less frequent mild reaction, neurodermatitis, beginning with itching and desquamation requires that the drug be halted. When the drug is discontinued, Vitamin B and Cal-Lactate mixture should be administered until the reaction has subsided.

The less frequent but more severe reactions such as hepatitis and psychosis necessitate stoppage of the drug and instituting muscular injections of Vitamin B Complex

and anthiomalin (1.5cc) every other day for three days.

Medical Profession Lacks Concern

The control of leprosy in Ceylon requires a dual approach of trying to overcome centuries of myths, superstition, fears, dreads and disinterest, and hopefully instituting new policies and training new personnel. According to Dr. Fonseka, the Ceylonese medical profession by its own fears and disinterest contributes to the perpetuation of ancient myths and superstitions.

Internists and surgeons are quite conscious of the prestige and respect they command from the Ceylonese public. Under the government system of socialized medicine, most of Ceylon's physicians are salaried according to years of employment. Even with such salary guarantees, the fear of loss of prestige and respect is so great that it is the rare doctor who devotes any time to leprosy patients. This results in failure to treat the effects of leprosy. The most noticeable is disfigurement, which is treatable only by neurosurgery, orthopedic surgery, ophthalmic surgery and plastic surgery. The surgeons claim they are not disinterested but desire only certain changes in Hendala's operating suite. Dr. Fonseka claims that if these changes could be made, they would again delay. Nurses and other paramedical help mirror the physicians' attitudes, as is evidenced by lack of such personnel at the various leprosy establishments.

On the contrary, Ceylonese physicians have no reservations about treating patients with hepatitis, dysentery, tuberculosis or other medical diseases, or of performing orthopedic, cardiac, and neurologic surgery on non-leprosy patients.

An even more serious limitation of the care of leprosy patients results from lack of concern of the Health Ministry. On several occasions they have attempted to limit the already inadequate budget of the leprosy campaign.

The major diagnostic problem of leprosy in America is the low index of suspicion among physicians. Even though fears and dreads of leprosy do exist among a small percentage of laymen, leprous and non-leprous patients receive the same thorough care from the physician. If a patient needs special care or surgery, he can be referred to the U.S. Leprosarium in Carville, La. or to the U.S. Public Health Service clinics

in San Francisco or San Pedro, California and New York City.

While trying to uproot ancient myths and fears, Dr. Fonseka believes that hospital based leprosy centers managed by campaign officers would be instrumental in further leprosy control efforts. In small hospitals these "leprosy treatment centers" could dispense medicines prescribed, massages and exercises, and apply casts and splints. Larger centers could provide physiotherapy and reconstructive surgery. Officers at all of these centers should not only instruct groups of patients in the prevention and care of leprosy's complications, but work closely with the local Public Health Inspector to register, examine and treat contacts. Cod liver oil, worm treatment, and milk (in the case of children) should be the basic treatment of contacts of non-infectious and infectious cases; in the latter case graduated doses of Dapsone should also be given on the following schedule:

5- 9 yrs. of age	10 mg	} 2-3 × weekly
10-14 yrs. of age	15 mg	
15-19 yrs. of age	20 mg	

Leprosy Control

Better leprosy control will require the effective use of every available means of communication; consistent use of radio, films, newspapers, leaflets, posters, advertisements, and discussions with various religious and rural societies. The theme, according to Dr. Fonseka, should emphasize sympathy and understanding for leprosy patients, not social ostracism due to outmoded myths and superstitions.

As Dr. Fonseka says: "The hope of recovery and restoration to society is the strongest incentive to early isolation and early treatment, and those who work to remove that hope only increase the difficulty of controlling leprosy."

In conclusion, the establishment of more leprosy centers staffed with interested personnel, with a consistent public education program will all contribute to better leprosy control.

What is undoubtedly true in Ceylon for leprosy is true to a greater or lesser degree for any disease in any country where myths rather than facts prevail. ◀

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"1. Use special handles and holders for hot articles.

2. Inspect their own hands and feet daily for thorns or blisters. Special attention needs to be paid to employment such as cooking and heavy rough work. To prevent these problems a change of occupation selected either by the physiotherapist or social worker is needed.

3. Dress and splint every wound and keep it splinted with coconut shell in a functional position until it heals.

4. Wear well fitting shoes or sandals and avoid any shoes made with nails.

5. Rest the hands during lepra reactions and when they are swollen. A splint should be provided for such occasions.

6. When paralysis and clawing occur they should begin a daily routine of oil massage and exercise designed to keep fingers fully mobile.

7. As part of this educational program, the patient may need advice about a form of employment that will not harm his hands or over-tax his feet."

7. Fonseka, Paul de, M.D., *Information about Leprosy*, Department of Health, Colombo, Ceylon, 1960.

Obituaries

***Chester Coggeshall**, Chicago, died June 2 at the age of 61. He was a founder of the Chicago Diabetes Association.

***Alice W. Hamby**, Elmhurst, died in April at the age of 46.

***Harry Jackson**, Chicago, died April 22 at the age of 89. He was an assistant professor of surgery at Northwestern University.

***Fred P. Long**, Peoria, died April 26 at the age of 66. He was the Peoria City-County Health Director since 1950.

***James B. O'Neill**, Palos Heights, died April 25 at the age of 53. Dr. O'Neill was a heart specialist.

***Michael I. Reiffel**, Chicago, died May 30 at the age of 75. He was a member of the ISMS Fifty-Year Club.

*Indicates member of Illinois State Medical Society.

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THE VIEW BOX

(Continued from page 70)

Diagnosis:

Diagnosis is left middle cerebral artery occlusion. The arrow points to the site of almost a complete occlusion of the left middle cerebral vessel. The area which is normally supplied by the middle cerebral artery is completely avascular and is seen between the posterior and cerebral circulation inferiorly and the anterior cerebral circulation superiorly. Films B and C reveal early retrograde filling high over the convexity from the anterior cerebral artery. The collateral flow enters in the low and posterior position to fill the posterior temporal branch of the middle cerebral artery from the posterior cerebral artery via pial anastomoses. In Figure C we see that the original bare area demonstrates vascularity which has resulted from collateral circulation and are undoubtedly aiding the patient in the degree of recovery which has been demonstrated clinically.

There are three principle cranial collateral pathways: 1) through the Circle of Willis; 2) external to internal carotid anastomosis, a) ophthalmic artery reversed flow (most commonly observed), b) middle meningeal branch of the external carotid to the meningeal branch of the cerebral artery; 3) over the surface of the brain's so-called meningeal or pial anastomoses between and among the three major cerebral arteries.

These collateral pathways exist awaiting demand and enlarge as demand for flow rate and volume increases.

Reference

Love, L. Hill, B. J., Larson, S. J. Raimondi, A. J., and Lescher, A. J.: "Cranial Collateral Pathways in Stroke Syndrome." *American Journal of Roentgenology, Radium Therapy and Nuclear Medicine*, Vol. 98, No. 3, pages 637-646, 1966.

"The Treatment of Parkinson with Levodopa" a 14 minute, color, sound presentation covers the symptoms and bio-chemical aspects of the disease, prior treatment, the establishment of dosage schedules, and complications of therapy. The film may be obtained by contacting Eaton Medical Film Library, Eaton Laboratories, Norwich, New York 13815 or any Eaton sales representative.

Illinois Medical Journal

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Reduce Cell Damage from Anti-Leukemic Drugs

Halothane and nitrous oxide, two common anesthetics, have been found to reduce damage to healthy cells by anti-leukemic drugs. Experiments with 5,000 laboratory mice led to this conclusion, Dr. David L. Bruce, associate professor of anesthesia in the Northwestern University Medical School, Chicago, announced.

If the results ultimately are confirmed in humans, a significant contribution hopefully will have been made to the treatment of leukemia by permitting more vigorous and successful therapy with arabinosyl cytosine (ara-C) and vinblastine, two potent anti-leukemic drugs which destroy malignant cells, but unfortunately are often toxic to healthy ones.

In essence, Bruce and two associates, Drs. Hsui-San Lin and W. R. Bruce of the Ontario Cancer Institute, Toronto, discovered that light anesthesia with either halothane or nitrous oxide reduced significantly the destruction of normal cells by ara-C or vinblastine. Their experiments with some 5,000 laboratory mice showed no reduction in the ability of anti-cancer agents to kill malignant cells when the cancer cells were given concurrently with the anesthetics.

Dr. D. L. Bruce said the experiments

demonstrate that halothane or nitrous oxide given concurrently with either of the chemotherapeutic agents will protect healthy cells from toxicity without reducing the effectiveness of the anti-cancer drugs on leukemic bone marrow cells.

The U.S.-Canadian findings are published in the June issue of **Cancer Research**.

In their research, the three scientists vaporized the cages of leukemic mice with the two anesthetic agents and later administered ara-C and vinblastine to the animals. The scientists later sacrificed the mice and found that the anesthetic-cancer drug combination had no effect on normal bone marrow cells and that the effectiveness of the cancer drugs on malignant cells was unimpaired.

By contrast, damage to healthy cells or the spread of malignant cells was observed in other groups of mice, who had received the anesthetics alone, one cancer drug alone, or neither the anesthetics nor the cancer drugs.

The scientists concluded from their studies that protection of normal cells by anesthetic-cancer drug combinations may indicate a general phenomenon whereby anesthetics increase the selectivity of cytotoxic drugs by protecting normal cells against them.

ON THE COVER

This month's cover depicts the asthma sufferer, who according to Donald L. Unger, M.D., in his article on page 123, "Why does asthma occur at night?" finds the night hours the most difficult. Cover art by Bob Solomon of Star Litho-Art.

The September issue of the *Illinois Medical Journal* will feature two other relevant articles in these times of air pollution: "Allergic Rhinitis and Air Pollution: A Double-Blind Crossover Analysis of Two Oral Nasal Decongestants," by Drs. Peter S. Mayer, and Arthur E. Sovitt; and "Metearalag Factors in the Fallout of Pollens and Molds," by Drs. Eugenia and Hermon Heise. In addition, Dr. Kenneth H. Schnepf's article, "Licensure Problems in Illinois," should be quite informative in view of current concern with licensing problems. A second article will give further elucidation on this topic.

BLUE SHIELD REPORT



FOR *Illinois Physicians*

National Accounts Outlined

The National Association of Blue Shield Plans has requested that all Blue Shield Plans provide a comprehensive usual and customary benefit program that can be used in national account proposals. The National Association of Blue Shield Plans' specifications for this program include twenty different benefit categories. The first twelve of these are considered standard benefits and the remaining eight are considered optional.

Illinois Medical Service will offer twelve standard benefits (plus variations within each benefit) by September 1, 1970.

Benefits under a national contract will vary from group to group only in that they may purchase the optional riders. Every contract will include:

1. **Surgical Service:** operative or cutting procedures, the treatment of fractures or dislocations, and certain endoscopic and other procedures.
2. **Anesthesia Service:** anesthesia administered in connection with services covered under the contract when ordered by the attending physician.
3. **Radiation Therapy Service:** the treatment of diseases by x-ray, radium or radioactive isotopes.
4. **Diagnostic X-Ray:** an x-ray examination, including interpretation and report.
5. **Laboratory and Pathology:** laboratory and pathological examinations.
6. **In-Hospital Medical Care:** any medical treatment of a condition not related to surgical or maternity care.
7. **In-Hospital Medical (TB, Mental, Drug Addiction and Alcoholism):** benefits are provided for the treatment of pulmonary tuberculosis, mental disorders, drug addiction and chronic alcoholism.
8. **Maternity care:** benefits are provided for maternity services, including necessary pre-natal and post-natal care, furnished to the employee or the spouse of an employee enrolled on a family certificate only after such certificate has been in force for 270 consecutive days.

9. **Out-Patient Emergency Care:** those necessary services performed by a physician for an accidental injury or for the initial visit at the onset of a medical emergency.

10. **Consultations:** benefits are provided for the service of another physician, when requested by the attending physician who is in charge of the case. Benefits are provided only on an in-patient basis.

11. **Out-Of-Hospital Diagnostic X-ray, Laboratory and Pathological Services:** benefits for these diagnostic services are available only to members who are not registered bed patients.

12. **Physical Therapy:** the treatment of disease or injury by physical means such as massage, hydrotherapy, heat or similar modalities as may be prescribed by a physician.

A Usual and Customary program, properly carried out, and with the continued cooperation of the medical profession, will accomplish several long desired objectives: a greater return for physicians from third-party agencies; a more appropriate share of the prepayment dollar; a greater return to the public in benefits provided; and predictability of medical charges to the consumer.

AMA President; End Physician Shortage

The physician shortage can "in large measure" be solved through a major overhaul in methods of training doctors, according to the new president of the American Medical Association and member of Illinois Blue Shield's Board of Trustees since 1953. In his inaugural address, Dr. Walter C. Bornemeier called for new ways of training doctors, including the use of physicians in private practice as teachers. Dr. Bornemeier said at least 50,000 physicians involved in teaching, too-lengthy residency programs, and research could be more valuably related to patient care. This diversion of doctors "has aggravated the current shortage of medical services for the public," he said.

ASK BLUE SHIELD

• • • ABOUT MEDICARE

EKG's in Independent Laboratories

The Social Security Administration has revised Medicare regulations and now permits reimbursement to be made for taking an EKG tracing in an approved independent laboratory. Former regulations required that the tracing be taken under the direct supervision of a physician. Now, payment can be made as long as the individual performing the tracing meets the requirements of a physician, laboratory technologist or technician.

No change has been made in the regulations governing the approved reading and interpretation of the EKG. This still must be performed by a physician.

If the laboratory charge includes not only the taking of the EKG but also its reading and interpretation by a physician, that physician needs only to be identified on the bill or the SSA-1490. In fact, no claim for a separate physician's charge will be reimbursed unless it is that of the attending physician or a consultant. This provision, too, is qualified in that reimbursement will be made for this charge if "it is the normal practice to make extra charges for this service, over and above the regular office visit charge."

When submitting a Medicare claim for payment, it is necessary to supply the following specific information:

1. Indicate the name and address of the referring physician.
2. In an emergency situation, "i.e., where the patient is or may be experiencing what is commonly referred to as a heart attack," please furnish evidence that the physician was in attendance at the time the service was performed or that he was present immediately after the service was completed. In this situation the presence of a physician is required.
3. In a non-emergency situation, include a description which will clearly indicate that the EKG was ordered for a covered diagnosis, and was not part of a routine physical examination.
4. If the EKG tracing is taken in the Medicare beneficiary's home, and the charge for the service is higher than it would be if the same service had been performed in the laboratory, please attach a statement describ-

ing the medical necessity for performing the service outside the laboratory. If this is not done, or it is not medically necessary to perform it in the home, payment will be made according to the reasonable charge for performing the service in the laboratory.

Before a claim can be considered for payment, the physician must provide the laboratory with a written referral or order for the EKG's according to Medicare regulations. The order should contain all the information listed above as necessary on a claim. Also, the laboratory records must indicate the name of the individual who actually performed the EKG.

By observing these regulations Illinois Blue Shield, as Part "B" carrier in the counties of Cook, Kane, Lake, DuPage and Will, will be able to prevent delays in processing.

Limitations on Injections

Medicare will allow payments for injections which are considered a specific or effective treatment for a specific condition or diagnosis. Injections given for the "general good and welfare of the patient" are not considered a covered service according to Medicare regulations.

Vitamin B-12 and Endrate are two injections which have caused some confusion. The Social Security Administration has now determined specific conditions and diagnosis for which these are considered a covered injection.

Vitamin B-12 is considered a specific therapy for:

Certain anemias: pernicious anemia; megaloblastic anemias; macrocytic anemias; fish tapeworm anemia.

Certain gastrointestinal disorders: gastrectomy; malabsorption syndromes such as sprue and idiopathic steatorrhea; surgical and mechanical disorders such as resection of the small intestine, strictures, anastomoses and blind loop syndrome.

Certain neuropathies: posterolateral sclerosis; other neuropathies associated with pernicious anemia; during the acute phase or acute exacerbation of the following—multiple sclerosis, trigeminal and glossopharyngeal neuralgia, neuropathies of malnutrition and alcoholism, tabes dorsalis, causalgia, postsympathectomy paresthesias, diabetic neuropathies and herpes zoster and other inflammatory neuritis not due to mechanical or traumatic etiology.

Endrate is considered a covered injection when administered to selected patients for the emergency treatment of hypercalcemia and for the control of ventricular arrhythmias and heart block associated with digitalis toxicity. It may be indicated in preparation of hypercalcemic patients for emergency surgical procedures and for temporary symptomatic treatment of patients with scleroderma.

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DIARRHEA (functional) . . . *the first 400 mg. tablet usually relieves the discomfort of diarrhea so promptly that it ceases to be a bother.*

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BLADDER SPASM . . . *relaxation is immediate. One or two tablets condition the bladder for cystoscopy in one hour.*

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WARNING: Do not give in advanced kidney or liver disease.

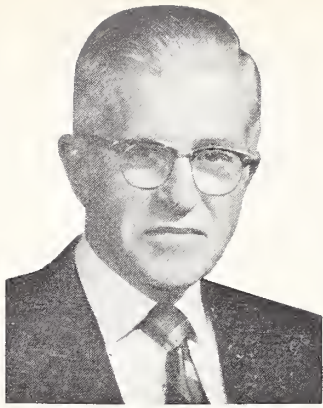
PRECAUTIONS: Trocinate relaxes all smooth muscles. Large dosage or prolonged usage may cause feeling of weakness or can theoretically precipitate gall-bladder colic, due to relaxing the vascular and duct systems. Caution should be observed in patients with urinary bladder obstruction. **DOSAGE:** 400 mg. May be repeated in 4 hours. After relief, lengthen the dose frequency. (see side note)

NOTE: The high therapeutic index of Trocinate permits its administration in dosage sufficient to relieve smooth muscle spasm promptly. 400 mg. dosage usually creates a therapeutic blood level. In reducing dosage after relief, lengthening the time between dosage rather than lessening the recommended dose is preferable. The prompt direct action allows a consciousness of the first suggestion of return of symptom . . . a guide to dose spacing and to determining when treatment is complete. A prescription for twelve or sixteen 400 mg. tablets will usually correct spasm and leave a few tablets for a reserve.

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J. Ernest Breed

The President's Page

ISMS receives praise on public health programs

At the 1970, ISMS convention, our members were congratulated for their contribution to public health programs in Illinois by Dr. Franklin D. Yoder, director of the Department of Public Health.

Dr. Yoder told our House of Delegates he took special pleasure in commending Illinois doctors at a time when criticism of the medical profession seems all too common. His remarks specifically mentioned physicians' cooperation in the state's immunization campaign against German measles that has made this program one of the most successful in the country.

The Illinois Department of Public Health had requested the cooperation of our members in countywide immunization programs because of the alarming increase of birth defects due to German measles.

"The response (from ISMS members) was nothing short of remarkable," Dr. Yoder told us. He said, thus far 600,000 children in 69 counties have been inoculated and the remaining counties would be covered by the beginning of the new school year.

Dr. Yoder said that by reaching 600,000 children at such an early date, Illinois ranked second highest in the country in terms of rubella protection.

The praise given to ISMS members by Dr. Yoder is well-earned. According to a recently conducted ISMS survey of county medical societies, nearly 2,550 physicians DONATED more than 12,500 free man-hours of time, worth an estimated \$660,000

to public health programs during the past year.

More than 800,000 children in all areas of the state benefited from free inoculations or screening programs during the 12-month period ending May 1. The inoculation programs helped protect children from rubella, measles, diphtheria, smallpox and polio. Screening projects included preschool visual exams, hearing and vision tests, physical examinations, and tuberculosis and diabetes testing.

These statistics are very conservative because less than 25% of the state's county societies responded to the survey. Since most county societies participate in public health programs, a more complete response would show far greater cooperation and higher statistics.

The ISMS survey was conducted to help discredit the many recent charges in the national press and television networks criticizing physicians and present forms of health delivery. Our survey results certainly disprove charges that physicians are no longer concerned about their patients . . . just the size of their bank accounts.

I am proud to be a member of this medical society whose concern for people is more than an idle boast and is backed up with statistics such as these.

A handwritten signature in cursive script that reads "J. Ernest Breed M.D.".

Clinics for Crippled Children Scheduled

Twenty-seven clinics for Illinois' physically handicapped children have been scheduled for September by the University of Illinois, Division of Services for Crippled Children. The Division will hold 22 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical, social, and nursing service. There will be three special clinics for children with cardiac conditions and rheumatic fever, and two for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

September 1—Alton—Alton Memorial Hospital
 September 2—Carmi—Carmi Township Hospital
 September 2—Hinsdale—Hinsdale Sanitarium
 September 2—Rock Island Cerebral Palsy—3808 Eighth Avenue
 September 3—Sterling—Community General Hospital
 September 3—Effingham—St. Anthony Memorial Hospital
 September 8—Peoria—St. Francis Children's Hospital
 September 8—East St. Louis—Christian Welfare Hospital
 September 9—Champaign-Urbana—McKinley Hospital
 September 9—Joliet—St. Joseph's Hospital
 September 10—Springfield—General—St. John's Hospital
 September 10—Anna—Union County Hospital
 September 10—Macomb—McDonough District Hospital
 September 11—Chicago Heights Cardiac—St. James Hospital

September 15—Rock Island Area General—Moline Public Hospital
 September 16—Evergreen Park—Little Company of Mary Hospital
 September 16—Jacksonville—Norris Hospital
 September 17—Rockford—Rockford Memorial Hospital
 September 17—Decatur—Decatur Memorial Hospital
 September 17—Elmhurst Cardiac—Memorial Hospital of DuPage County
 September 22—Peoria—St. Francis Children's Hospital
 September 22—Belleville—St. Elizabeth's Hospital
 September 23—Centralia—St. Mary's Hospital
 September 23—Elgin—Sherman Hospital
 September 23—Springfield Pediatric Neurology—Diocesan Center
 September 24—DuQuoin—Marshall-Browning Hospital
 September 25—Chicago Heights Cardiac—St. James Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

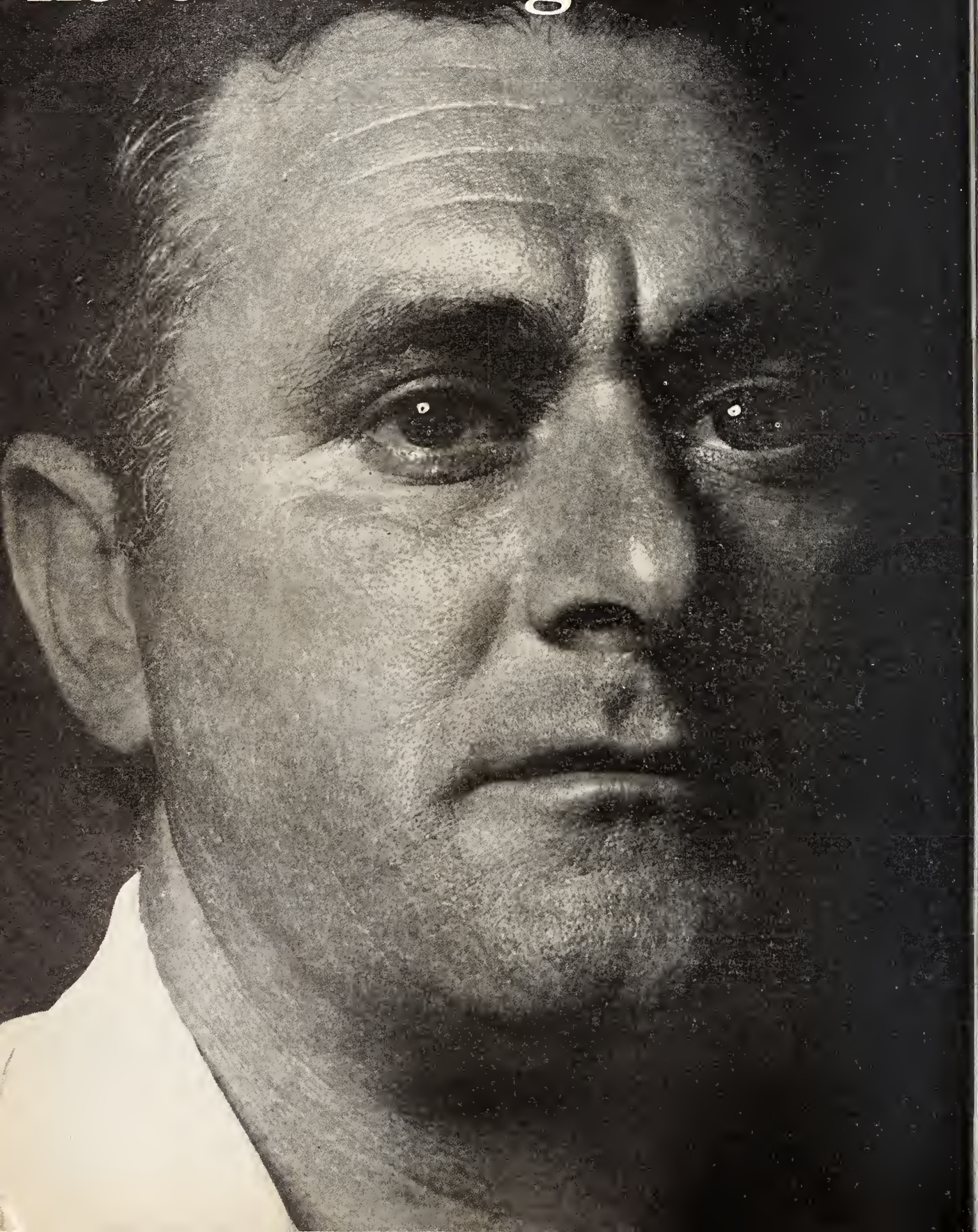
In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

A Common Need for All of Us

"Concentrations of populations, outmoded facilities, and the concentration of many pollutants pose a threat to many communities across the nation. All of us share a common need for air and water and their many uses. All of us have a stake in bringing about sound management of these vital resources."—Arch N. Booth, executive vice president, Chamber of Commerce of the United States.

The negative power of anxiety...

**This man thinks he may
never work again.**



Why does asthma occur at night?

By DONALD L. UNGER, M.D./DES PLAINES

"Of all the circumstances attending the commencement of an asthmatic paroxysm, none is more constant than the time at which it occurs. This is almost invariably in the early morning, from two to six o'clock."

Since Salter¹ wrote these words in 1882, there have been several explanations for this timing; my purpose is to review them. While Salter believed that the horizontal position was a cause of nocturnal asthma, he still described a night porter who slept all day and yet had his asthma at night. The horizontal position leads to accumulation of bronchial secretions and embarrasses respiration because of pressure of the abdominal organs against the diaphragm.² It also causes a passive decrease in bronchial diameter.³ Since almost all asthmatics sit up

during attacks, it is obvious that lying flat makes them worse.

The importance of prolonged exposures during sleep has also been emphasized,² as the average person spends about one-third of his life in his bedroom. Allergens there would favor the development of attacks, even though sensitivities to them might be slight. Because feathers are usually a minor allergen, it may take a long time for them to cause symptoms, but sleeping several hours on a feather pillow may cause symptoms. Nocturnal asthma suggests sensitivity to feathers and mattresses,⁴ and mattresses are the prime source of allergenic dusts. Asthma also predominates at night, however, in patients sensitive to pollens and foods.⁵

Ground level pollen counts are higher at night than during the day. Using an airplane, Heise⁶⁻⁷ did a series of pollen and mold counts at various locations, altitudes and times of the day. He described an easily visible cloud layer containing maximum concentrations of allergenic particles. This cloud rises from early afternoon until about eight at night, and then slowly falls until dawn when there is ground fog. These studies were done during the late summer when hot air rising carried particles up-



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wards during the day, the cloud lowering at night as the ground cooled. This may explain why pollenosis is worse in the early morning. Since air pollutants are present in this cloud, patients not sensitive to pollens and molds should also be worse about dawn. No such studies were done during the winter months to determine if a similar pattern is present.

Circadian rhythms in body functions also relate to nocturnal asthma. For example, vital capacity and forced expiratory volume are normally lower at night,⁸ and this is much more pronounced in asthmatics.⁹ Smaller amounts of histamine are needed to lower these tests at night, this apparently being a fundamental feature of asthmatic and bronchitic patients.¹⁰⁻¹¹

With diurnal variations in steroid levels, attacks of asthma occur mainly when adrenal activity is at its trough.¹² Plasma 17-hydroxycortico-steroid levels fall during sleep, reaching a nadir between two and four in the morning.¹³ Reversing the times of sleep and activity reverses this circadian cycle, but the response is independent of position and light.

In summary, the causes of nocturnal asthma can be divided into those from outside the body and those from within. External factors include increased exposures to bedroom antigens, pollens, molds and air pollutants. Internal changes are decreased pulmonary function and levels of adrenal hormones, and increased sensitivity to histamine. The horizontal position causes narrowing of the bronchial tree, accumula-

tion of secretions and pressure of the abdominal contents against the diaphragm. Many factors increase asthma at night and these vary from person to person, season to season, and expose the exposure. ◀

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Obituaries

***Leroy Fatherree**, Urbana, died June 15 at the age of 69. He served as state director of the Illinois Department of Public Health.

***Chester Coggeshall**, Chicago, died June 2 at the age of 61. He was founder of the Chicago Diabetes Association.

***Earl W. Cauldwell**, Lemont, died May 16 at the age of 87. He was a member of the ISMS Fifty Year Club.

***Rudolph A. Schaefer**, Plano, died February 2 at the age of 91. He was a member of the ISMS Fifty Year Club.

***Loring S. Helfrich**, Moline, died January 16 at the age of 59. He was a past president of the Rock Island County Medical Society.

***Arthur T. G. Remmert**, Chicago, died February 14 at the age of 72.

***Edwin S. Braden, Jr.**, Northbrook, died January 18 at the age of 51.

***Margaret M. Kunde**, Chicago Heights, died June 30 at the age of 82.

***Chauncey C. Maher**, Chicago, died at the age of 72. He was a former director and chairman of Scientific Exhibits for the ISMS annual meetings.

***Alva A. Knight**, Chicago, died June 22 at the age of 81.

***Anton J. Vleck**, LaGrange, died July 4 at the age of 54.

***Henry W. Hilsten**, Chicago, died July 3 at the age of 70.

*Indicates member of Illinois State Medical Society



IMJ

**SURGICAL
GRAND
ROUNDS**

Surgical Grand Rounds are held weekly on Saturday at 8:00 a.m. in Offield Auditorium at Passavant Memorial Hospital. Patient presentations from Chicago Wesley Memorial, Passavant Memorial, and the Veterans Administration Research Hospitals form the basis of the discussions. This case report was part of the Surgical Grand Rounds on March 21, 1970.

Intermittent Jaundice

EDITED BY JOHN M. BEAL, M.D.

Case Report:

Dr. John S. Williams: A 75-year-old, white, male was admitted to the Veterans Administration Research Hospital on February 16, 1970, with abdominal pain of two days' duration. After eating fried chicken for dinner two days prior to admission, he developed constant midepigastria, and diffuse upper abdominal pain approximately two hours later. The pain kept him awake but he did not have nausea, vomiting or diarrhea. He had not had similar pain prior to this episode. He denied fever or chills. Because the pain persisted, he came to the V.A. Research Hospital. Soon after the onset of pain, he noticed that his urine was darker than normal.

Past history: eight years prior to admission a suprapubic prostatectomy had been performed for benign prostatic hypertrophy.

Physical examination: the patient was well-nourished and was not in acute distress. Pulse, blood pressure, and temperature were normal. The sclera were mildly icteric. Chest and heart were unremarkable.

Abdominal tenderness was absent and good bowel sounds were present. Rigidity and voluntary guarding were not present.

Admission blood counts and urinalysis were unremarkable. Two days after admission, after eating tuna fish, he again developed acute right upper quadrant pain, without nausea, vomiting, chills or fever. Examination revealed tenderness in the right upper quadrant.

Multiple laboratory determinations were obtained. Admission values included serum bilirubin of 4.9 mgm.%, alkaline phosphatase, 49 units, and serum amylase of 560 units. Amylase values were within normal limits within 24 hours but bilirubin levels varied from 2.8 to 7 mgm.%. SGOT was 50 units. An oral cholecystogram was obtained before jaundice was detected. A percutaneous cholangiogram was performed preoperatively.

Dr. Abram Cannon: A very faint visualization of the gall bladder is seen after oral administration of the contrast material. As nearly as I can tell in this faintly outlined

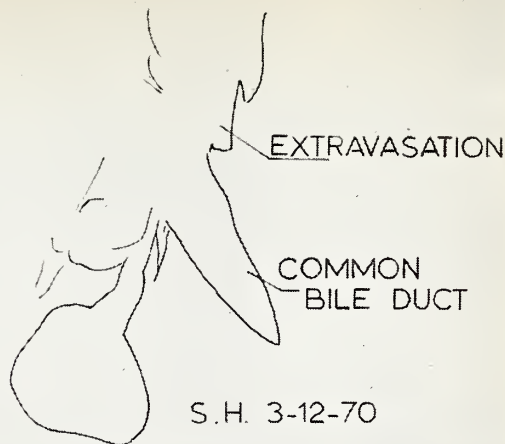


Fig. 1. Percutaneous cholangiogram demonstrated obstruction of the common bile duct with a tapered end, which suggested neoplasm.

gall bladder, there are no stones. There is a small diverticulum of the upper esophagus. The stomach and colon is normal.

In the presence of jaundice, the poor visualization of the gall bladder is probably due to decreased excretion of contrast material. Without seeing stones, I don't think the gall bladder can be called abnormal.

The percutaneous cholangiogram shows good filling of the common duct. There is some extravasation of the contrast material about the bed of the liver, but there is good visualization of the common duct. The duct is obstructed. The caliber is greater than usual and there is a tapering distal end to the common duct (Fig. 1). Usually, with a stone, there will be a rather abrupt termination of the duct without the tapering that is seen in this patient. The probability of a tumor about the distal end of the duct is great, although the duct itself is not irregular.

Dr. Robert Glass: The percutaneous cholangiogram was performed immediately before operation and was helpful. At the time of operation the gall bladder was found to be slightly thickened but without stones. Stones were not present in the common duct, which was perhaps 11 or 12 mm. in diameter. Stones were not found in the intrapancreatic portion of the duct. There was a 4 cm. diameter mass in the head of the pancreas. With the results of the percutaneous cholangiogram, with the absence of stones, in a 75-year-old patient with a mass in the head of the pancreas, Roux-en-Y cholecystojejunostomy was selected. The patient has done well and his jaundice is diminishing.

Percutaneous cholangiography had its origin in 1920, when Burkhardt and Mueller, in Germany, injected the gall bladder through a percutaneous approach and visualized the extrahepatic biliary tree. In 1924, Graham and Cole injected tetrabromophenolphthalein intravenously and visualized the gall bladder and biliary tree. A year later, the oral cholecystogram was demonstrated by them. Graham and associates wrote a book in 1928, *DISEASES OF THE LIVER AND BILIARY TRACT*, in which Burkhardt and Mueller's work was mentioned only to condemn it. In 1937, percutaneous transhepatic injection of the biliary tree was first done by Huard and Do-Xuan-Hop. In the United States in 1952, Carter and Saypol reported transhepatic injection of radiopaque material. In 1962, Glenn reported percutaneous cholangiography in 46 patients. Glenn stated that the procedure was useful in jaundice of uncertain etiology and that extrahepatic obstruction could be differentiated from jaundice caused by parenchymal disease. In 46 patients, he was able to visualize the extrahepatic biliary tree in 32, or 70%. In ten of the remaining 14, intrahepatic causes of jaundice were found ultimately.

Beal reported a series of cases in 1965, and reviewed the literature. In his experience, failure to visualize the extrahepatic tree with percutaneous cholangiography indicated a 75% probability that extrahepatic obstruction was not present.

The procedure is relatively safe. There are two major complications: bile leakage and hemorrhage. Both complications can be managed by subjecting the patient to operation when the percutaneous cholan-

giogram has been performed and obstruction of the biliary tree has been demonstrated.

Dr. James Apostol: This patient illustrates the advantages of percutaneous cholangiography. The problem in this patient was that his work-up indicated he had a common duct stone. He had a fluctuating bilirubin level. Initially, a gall bladder series was ordered and obtained without realizing that his bilirubin was already 3.5 mgm.% and the gall bladder did faintly visualize. There was mild right upper quadrant pain, but no signs of infection, and the gall bladder was not palpable. We were certain that he would have a common duct stone. Imagine our surprise when the percutaneous cholangiogram revealed evidence consistent with malignancy.

A further interesting point is that he had early obstruction. At the time of surgery, the gall bladder was not distended and the common duct was not appreciably enlarged. Therefore, it should have been difficult to perform a percutaneous cholangiogram on this patient. Dr. Lorenzo should make a few comments about his experience to insure success with this technique.

The final point is that at the time of surgery it was easy for us to very quickly make up our minds that this must be a malignancy. We know that if we had tried to make a definite pathological diagnosis, we would be unsuccessful in a significant percentage of cases, assuming that he does have a carcinoma of the head of the pancreas. Furthermore, with needle biopsy or with duodenotomy or common duct exploration, we would significantly increase the possibility of morbidity and mortality. Since the patient is 75-years-old, let us just accept the fact that the findings at the time of surgery, along with the cholangiogram were consistent with a carcinoma of the head of the pancreas.

Dr. Gabriel Lorenzo: Generally speaking, percutaneous cholangiography is not a complicated procedure. The cholangiogram is scheduled to be followed by laparotomy unless normal biliary ducts are found. The procedure is performed in the Radiology Department with the patient on the fluoroscopy table in the supine position. The skin over the lower chest and upper abdomen is prepared and draped, and the skin is infiltrated with 1% xylocaine in the midclavicular line, approximately 2 to 3

cm. below the right costal margin. A 6 inch, #18 gauge needle with a teflon catheter is held at a 45° angle cephalad and directed 20 to 25° medially, advanced through the abdominal wall and into the liver parenchyma to end as close as possible in the hilum. The position of the needle is then confirmed with the fluoroscope using the image amplifier. The stylet is removed and a 50cc. syringe containing 75% Hypaque or Renografin is attached to the needle. No attempt is made to aspirate bile. A small amount of the contrast material, 0.5 to 1 cc., is injected and with the help of the image amplifier it can be verified if the dye is entering one of the liver radicals, a vascular structure or infiltrating the liver substance. If the first attempt has been unsuccessful the needle is withdrawn 1 cm. at a time each time until a bile duct is visualized. At the completion of the procedure and before the needle is withdrawn I try to aspirate as much bile as possible to reduce the volume of fluid in the biliary tree. The patient is then taken to the operating room for laparotomy unless a normal, unobstructed biliary tract is found.

Dr. John Beal: Dr. Rosi, should a palliative procedure, such as cholecystojejunostomy be performed without biopsy of the pancreas?

Dr. Peter Rosi: Palliative procedures such as cholecystojejunostomy should be performed upon the clinical impression obtained during surgery without subjecting the patient to a biopsy of the pancreas which has certain hazards, such as pancreatic fistula, seeding of the peritoneum with malignant cells if the carcinoma is incised and false negative biopsies. Carcinomas of the pancreas are often associated with a chronic pancreatitis which makes it difficult to outline the site of the tumor. Biopsies of the pancreas under these conditions are unreliable. Adding a pancreatic biopsy to a palliative procedure would add unjustifiable risks to these often aged patients.

Dr. Robert Ryan: Is the Rose Bengal test useful in patients who are jaundiced?

Dr. Beal: The Rose Bengal and the other isotope studies are helpful, but like other tests, including the percutaneous cholangiogram, they have certain limitations. The liver scan will detect defects in the liver,

(Continued on page 177)



By LEON LOVE, M.D.

*Director, Department of Radiology, Loyola University Hospital
and Chairman, Department of Radiology, Loyola University
Stritch School of Medicine*

A 60-year-old male entered the hospital with a chief complaint of persistent abdominal pain of several days duration. Two

years earlier he had undergone ligation of the inferior vena cava because of repeated episodes of pulmonary emboli, which were not controlled by adequate anticoagulation therapy. He improved after surgery. Sputum cultures obtained during this admission were reported positive for tuberculosis. He was placed on I. N. H. At no time was the posterior mediastinal mass noted on radiographs taken up to six months before his present admission. The patient was a chronic alcoholic who admittedly drank about a fifth of bourbon daily. On admission the physical exam revealed a vague fullness and slight tenderness in the upper gastrum and slight edema in both lower extremities. An upper GI examination was done followed by surgery. What's your diagnosis?

1. Alimentary tract duplication
2. Lymph node enlargement such as lymphoma, tuberculosis, or metastases with displacement of the paravertebral shadow
3. Dissecting aneurysm of the aorta
4. Collateral venous channels
5. Mediastinal pancreatic pseudocyst

(Answer on page 177)

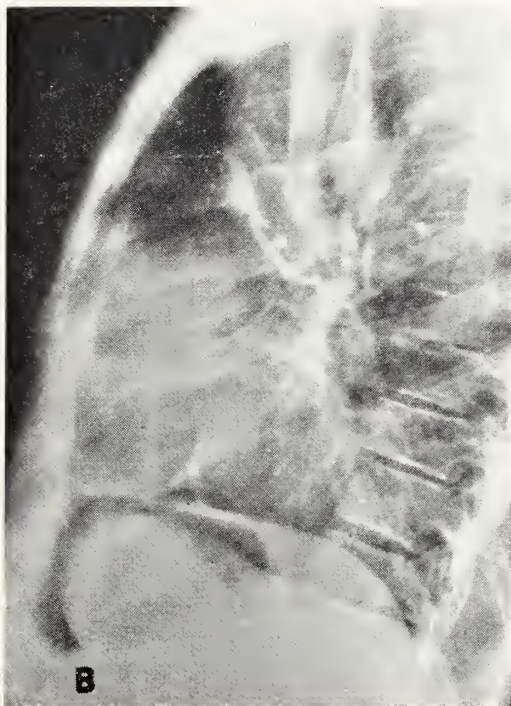


Fig. 1

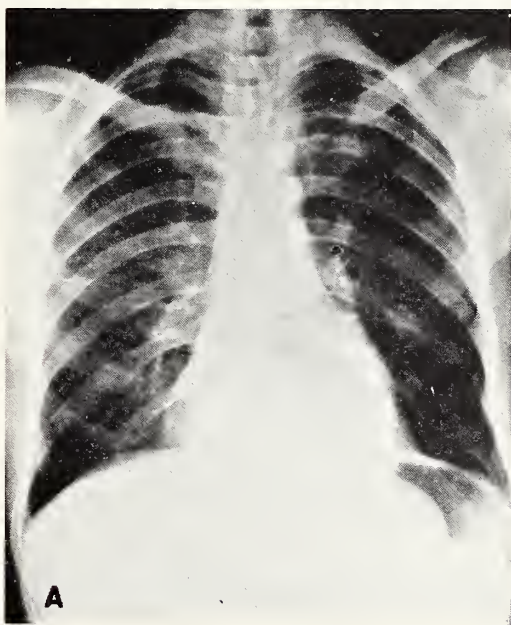


Fig. 2



Fig. 3

Argentaffine Carcinoma

(Carcinoid tumor)

Involving the ampulla of Vater

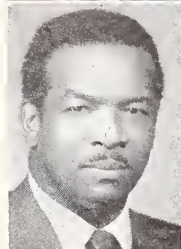
Argentaffine tumors of the duodenum are rare. A review published in 1959 indicates that only 28 authenticated cases had been reported up to that time.¹ In a series of 27 carcinoid tumors involving the gastrointestinal tract, only three were located in the duodenum.² Carcinoids originating in or involving the ampulla of Vater are even more rare as only six of these cases have been published to date, to the best of our knowledge.¹⁻⁵ The present report describes an additional case of argentaffine carcinoma (carcinoid tumor) involving the ampulla of Vater.

BY MARIO STEFANINI, M.D., JOHN
E. URBAS, M.D., AND FRED L.
CROCKETT, M.D./DANVILLE

Case Report

A 47-year-old Afro-American female was admitted with chief complaints of weakness and of jaundice of sclerae of three months duration. A previous episode six months earlier had lasted about two weeks. Physical examination confirmed jaundice of sclerae and visible mucosae. Liver was palpable 4 fbs. below the costal margin. Urine was dark and stool clay-like. A G-I series was described as indicating "extrinsic" pressure on duodenal bulb and descending duodenum. Gall bladder was not visualized, but no opaque calculi were identified. Urine was positive for bile and negative for urobilinogen. RBC count was 3.23 M/cu.mm.; hemoglobin 6.1 gms.%; hematocrit 18%; WBC count 8,100/cu. mm. with 1 stab form, 52 neutrophils, two eosinophils, 42 lymphocytes and three monocytes. Six per cent normoblasts were counted. Peripheral blood smear showed severe hypochromia, numerous ortho- and poly-chromatophilic target cells and increased number of platelets. A test with sodium metabisulfite was positive for appearance of sickle tactoids. Red cell fragility test showed values of 0.38% and 0.30% NaCl for initial and complete hemolysis (control: 0.42% and 0.34%, respectively). The presence of sickle cells and the decreased red cell fragility were confirmed by electrophoresis of hemoglobin on cellulose acetate paper, which showed a small (9.4%) component of hemoglobin S, consistent with sickle cell trait.

After patient had been on a standard 80 gms. fat diet for three days, stool exami-



Mario Stefanini, M.D. (top), is a pathologist and Director of Laboratories, St. Elizabeth's Hospital, Danville. He is a graduate of the Medical School, University of Rome and received an M.Sc. degree from Marquette University. Internship and residency training in pathology and hematology were taken at New England Center Hospital, Boston. Dr. Stefanini is a Diplomate, American Board of Pathology and an editor and author of texts dealing with his field. John E. Urbas, M.D. (center), received his M.D. from St. Louis University Medical School and interned at St. John's Hospital, St. Louis. He is in the private practice of medicine with special emphasis on general surgery. Fred L. Crockett, M.D. (bottom), received his medical training at Meharry Medical College and served a rotating internship at Pontiac General Hospital. He is currently in the private practice of medicine.

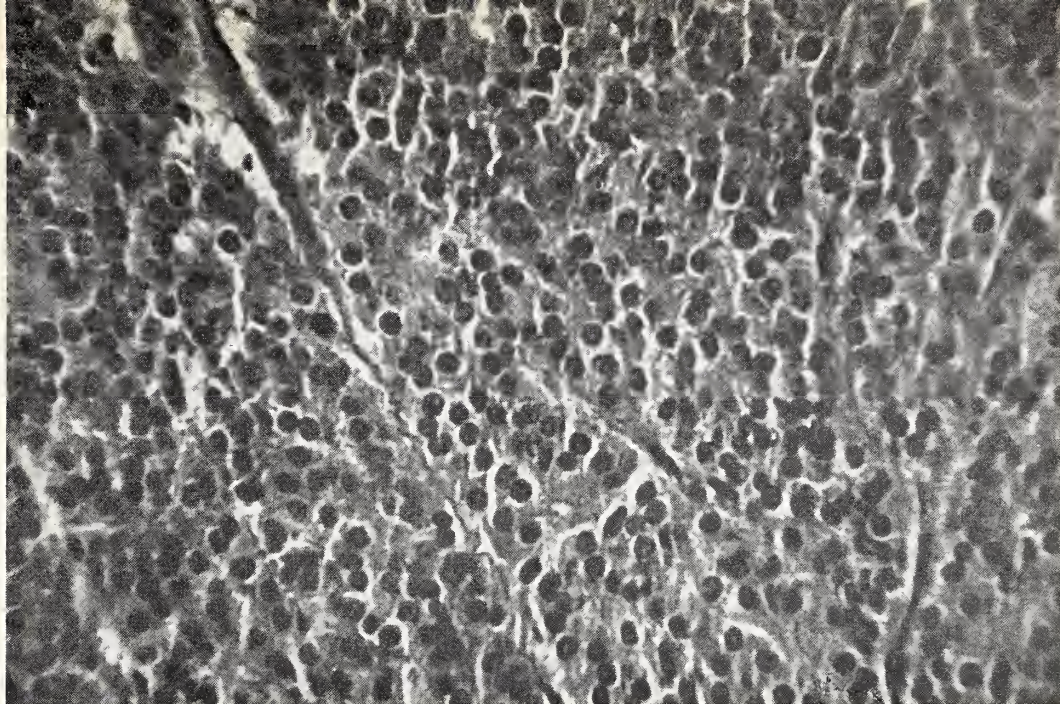


Fig. 1: Microscopic field of tumor. Note solid cords of cells with prominent dark nucleus and finely granular cytoplasm, separated by thick, fibrous septa.

nation with Nile blue and Sudan III stains revealed moderately increased amount of neutral fat and of undigested carbohydrates. Protein determination and electrophoresis of serum indicated a total protein of 7.4 gms.% with A/G ratio of 0.7 and elevation of β (24.2%) and γ (27.6%) fractions. Miscellaneous tests of liver function showed elevation of serum bilirubin (16.2 mgs.% total with 10.5 mgs.% direct reacting), and alkaline phosphatase (27.9 Bessey-Lowry's units). Cephalin flocculation test was 1+ in 24 hours. Serum GOT and GPT were 45 and 29 SIGMA units, respectively. Prothrombin time of plasma was 21 seconds (with control of 12.5 seconds) and was corrected to 16.2 seconds in four hours by the intravenous administration of 70 mgs. Hykinone. Tests of pancreatic function included a serum lipase of 1.1 Tietz units (normal: up to 0.6) and serum amylase of 205 Somogyi units. Serum leucine aminopeptidase was 120 Goldbarg-Rutenberg units (normal in females: 80-120).

Clinical Diagnosis

The tentative clinical diagnosis was obstructive jaundice with concomitant pancreatic disease in a patient with sickle cell trait. After blood transfusions had raised the hemoglobin level to 12.5 gms.%, the patient was brought to surgery. Since a spherical mass was palpable in the second portion of the duodenum, the duodenum was opened by anterior approach, to reveal

a mass measuring about 2 x 2.5 cm. in the area of the ampulla of Vater. After biopsy, the duodenum was closed, and a cholecystojejunostomy carried out. Following surgery, there was a rapid decrease in clinical jaundice and the level of bilirubin fell within two weeks to 3.2 mgs.% total and 2.7 mgs.% direct reacting. A test for 5-OH-indol-acetic acid in 24-hour urine was negative. The patient left the hospital asymptomatic and has experienced no recurrence of symptoms for 36 months following surgery. A stool study on a sample obtained from the patient on an unrestricted diet continues to show moderate increase in undigested carbohydrates and neutral fat.

Pathologic Findings

Biopsy yielded a portion of yellowish, soft tissue measuring 0.5 x 0.6 x 0.8 cm. Sections showed yellowish color throughout and gave a positive ferric ferricyanide reaction. Microscopic examination indicated that the tissue was composed of solid groups of spheroidal cells with large, hyperchromatic nuclei and finely granulated cytoplasm, supported by scanty and partly sclerosing stroma. (Fig. 1) Glandular patterns were not noted. A positive methenamine silver impregnation and positive ferric ferricyanide reaction of cells were obtained.

Comments

Intermittent obstructive jaundice was the presenting symptom in our patient, as in

cases previously described. Similarly, there was no evidence of "carcinoid syndrome" in our patient, nor could 5-OH-indol acetic acid be found in the urine.

The majority of carcinoid tumors located in the duodenum, with or without involvement of the ampulla of Vater, have been treated surgically with wide resection through a transduodenal approach and reimplantation of the common duct into the duodenum;¹ by local resection of the tumor along with a cuff of normal tissue;^{2,6} or with pancreatico-duodenectomy.^{5,7} One case treated with pancreatico-duodenectomy expired with disseminated metastases within eight months of the surgical procedure.⁷ Other cases were free of recurrence for periods of time extending from 21 months to 5.5 years, in agreement with the known lack of aggressiveness of these tumors. Our patient, who underwent a cholecystojejunostomy for the relief of the biliary obstruction, survives 36 months later and is asymptomatic. It is of interest that no evidence of pancreatic duct obstruction is clinically evident. Perhaps, while the duodenal end of Wirsung's duct is involved in the area of carcinoid tumor, the accessory Santorinian duct, opening into the duodenum about 2.5 cm. above the ampulla, remains patent. This consideration would explain why digestion of fats and of carbohydrates was originally and remains relatively unimpaired.

Summary

The report discusses an exceedingly rare case of argentaffine carcinoma (carcinoid tumor) in a 47-year-old female with sickle cell trait, involving the ampulla of Vater and presenting as obstructive jaundice. Cholecystojejunostomy was followed by clinical recovery. The patient is alive and apparently well 36 months after the original surgical procedure.

Acknowledgements

The authors express their appreciation to Mrs. Opal I. Deeken, CLA (ASCP), and Mrs. Dorothy J. Caldwell, CLA (ASCP) for technical assistance in the determination of the biochemical parameters of the patient.

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NEW PHARMACEUTICAL SPECIALTIES

by Paul deHaen

For detailed information regarding indications, dosage, contraindications, and adverse reactions, refer to the manufacturer's package insert or brochure.

Single Chemicals: Drugs not previously known, including new salts.

Duplicate Single Products: Drugs marketed by more than one manufacturer.

Combination Products: Drugs consisting of two or more active ingredients.

New Dosage Forms: Of a previously introduced product.

NEW SINGLE CHEMICAL

MITHRACIN Cancer Chemotherapy R
Manufacturer: Pfizer

Nonproprietary Name: Mithramycin (USAN)

Indications: Antineoplastic agent for inoperable testicular tumors

Contraindications: Thrombocytopenia, thrombocytopathy, coagulation disorder, an increased susceptibility to bleeding or impairment of bone marrow function. Use in hospitalized patients only.

Dosage: i.v., 25 to 30 mcg./kg. actual body weight for a period of 8 to 10 days.

Supplied: Vials, 2500 mcg. mithramycin
 100 mg. mannitol

DUPLICATE SINGLE PRODUCT

ALBACON Eye Preparation R
Manufacturer: Allergan

Nonproprietary Name: Naphazoline HCl

Indications: Sympathomimetic ocular decongestant for the symptomatic relief of minor ocular irritations and allergies.

Contraindications: Narrow angle glaucoma.

Dosage: 1-2 drops in each eye every 3-4 hrs.

Supplied: Plastic dropper bottles, 15 cc.

The doctor-patient dyad:

An interpersonal relationship model

BY H. H. GARNER, M.D./CHICAGO

The need of individuals to find answers to the illnesses, fears and uncertainties of life has in the past created a corps of professionals who feel that they could and should answer the call for help. This corps of helpers to those saying—"I'm sick and helpless"—is represented by the physician. To understand the nature of this relationship and why it works, we must understand the psychological significance of the role of the patient as a compliant, non-compliant, or critically appraising participant in the field of doctor-patient interaction. The goals for the treatment of any individual and the nature of the treatment process will be related not only to the physical disability but to the person who is sick, to his manner of relating, to his physician, and to the potentials for establishing a therapeutic focus from which the patient can benefit. The doctor-patient relationship has implications for both:

For the physician in regard to the patient it implies: 1) acceptance of the patient as a person—his interests, strivings and feelings; 2) acceptance of the right of the patient to find his own solution to his problems; 3) a respect for the patient's emotion-

ally determined attitudes toward his illness and the physician.

For the physician in regard to himself it implies: 1) discipline of his feelings, speech and behavior; 2) control of impatience, hostility and prejudice.

The emphasis in medical education on the acts of the physician directed at healing the patient has tended to blur the significance of the interactional process of the doctor-patient relationship. It is toward reviewing, clarifying, and describing some personal concepts about that relationship that I direct my discussion.

Models of patient-physician relationships

Having made the diagnosis, the physician draws a plan of action based not only on the diagnosis, but also on the unique ca-

H. H. Garner, M.D., is professor and chairman, dept. of psychiatry and neurology, the Chicago Medical School and the Mt. Sinai Hospital Medical Center. He is a researcher in confrontation techniques and methods in psychotherapy, and a pioneer in developing continuing education programs in psychiatry for non-psychiatrically trained physicians. Dr. Garner received his M.D. from the University of Illinois, College of Medicine. He is also consulting at the V.A. Hines Hospital.



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pacities and limitations of the physician, and on the relationship between the patient and physician. This relationship has received increased attention. The following is a graphic illustration of Rado's model. It is particularly applicable to a psychotherapeutic process.

RADO'S MODEL

ASPIRING LEVEL

Available in an adult capable and desirous of self-advancement.

SELF-RELIANT LEVEL

Adult capable of learning the simple know-how of daily life.

EXPRESSED ATTITUDES

I am delighted to cooperate.

I am ready to cooperate but I must learn how to help myself.

ADULT

CHILD-LIKE

PARENTIFYING LEVEL

Adult acts like a child, parentifies the therapist.

The doctor should cure me by his own efforts.

MAGIC CRAVING LEVEL

Discouraged adult hopes the therapist will work a miracle.

The doctor must do everything for me as by magic.

The following model has greater meaning for all doctor-patient contacts.

SZASZ-HOLLENDER

	<u>PHYSICIAN'S ROLE</u>	<u>PATIENT'S ROLE</u>	<u>CLINICAL APPLICATION</u>	<u>PROTOTYPE OF ROLE</u>
1. Activity Passivity	Does something to patient	Unable to respond or inert	Anesthesia, acute trauma, coma, delirium	Parent-infant
2. Guidance cooperation	Tells patient what to do	Cooperation—obeys	Acute infectious processes	Parent-child, or -adolescent
3. Mutual participation	Helps patient to help himself	Participant in partnership, uses expert help	Most chronic illnesses, psychoanalysis, psychotherapy	Adult-adult

The following represents what I feel is a valuable concept of doctor-patient relationship, which emphasizes how the patient's attitude toward the doctor can be recognized and understood as a guide to promoting restoration of health, or to a previously balanced level of functioning, and to the prevention of disorder in the future.

COMPLIANCE-PRIMARY

Originates in instinctual need to turn toward non-frightening stimuli in the environment. The base from which conforming and compliant behavior of later life develops and expands.

Patient to doctor attitude. A physiologic reflex action at instinctual level.

Clinical significance is limited: Sucking and turning movements of semi-stupor may be related, i.e., hypoglycemia. Deep trance states of hypnosis and psychoanalysis may contain elements of primary compliance.

COMPLIANCE SECONDARY- UNCRITICAL

Originates in infancy and childhood: Seeking of gratification—love—attention; avoids punishment.

Patient to doctor attitude: You are omnipotent and omniscient. I surrender my right to judgments and decisions.

Clinical significance: A characteristic response to moderate or extreme feeling of helplessness, fear or anxiety. Most patients will respond in this manner. The intensity gives an index for doctor-patient management interventions.

SECONDARY COMPLIANCE-AFTER CRITICAL APPRAISAL

Originates in infancy and childhood: Seeking gratification; the avoidance of punishment.

Patient to doctor attitude: I am basically trustful of you, but I would prefer to have more facts.

You seem to be a person who can't tolerate any questioning or accept the opinion of others. Since I want you and your skills, I will accept what you say without questioning. Uncritical compliance is fostered.

Clinical significance: Seen in elective situations or non-emergency surgery. The doctor has an unusual skill or has a reputation of having a skill which the patient feels is important to him. The patient complies despite his awareness of non-compliant feelings.

CRITICAL APPRAISAL

Originates in the earliest and later experiences of life which fortify problem-solving confidence.

Patient to doctor: I am observing what you do and say with discriminating perceptions and thought. I will respond positively if what you say and do makes sense.

Clinical significance: Usually will be most evident when sense of helpless anxiety and fear is minimal. The patient is likely to have a minimum of unrealistic attitudes about the omnipotent character of authoritarian figures.

NON-COMPLIANT-UNCRITICAL

Originates in the unlearned responses to the frustrations during earliest experiences with environment.

The learned non-compliant behavior of infancy and childhood as a means of controlling significant persons (similar to conditioned responses of Pavlovian experiments). Non-compliance is associated with achievement of goals, i.e., attention as a substitute for love and affection.

Patient to doctor: Automatic rejecting and non acceptance of recommendations—I won't, I won't,—I won't let you because I feel I shouldn't.

Clinical significance: Children in fairly large numbers may respond by such attitudes to first and subsequent visits. Adolescents and adults, who see the physician

as a coercing agent or punishing figure, may show an automatic type of negativism.

NON-COMPLIANCE-CRITICAL

Originates in experiences in which trust and devotion to authority was followed by painful and unpleasant experiences.

Patient to doctor: I can't accept recommendations from you. I refuse because I recognize I can't trust or believe you.

Clinical significance: The patient recognizes the recommendations or intended actions as of doubtful merit and as not in his best interests and often provokes hostility in the physician.

The Patient's Expectations

I have described most treatment processes as conducted in a two-person social system, i.e., the doctor-patient relationship. The others who enter this field of interaction—intern, resident, nurse, spouse, parent, sibling, friend—are usually subordinate actors on the stage of the patient-physician transaction. Most workers in the field of medicine are well aware of the *quid pro quo* attitude which the patient manifests about arrangements for medical care. This attitude expresses itself in the patient verbalizing rather freely about physical sensations, although he may be reserved and suspicious about his personal troubles or difficulties with others. In turn, after proper assimilation and coding of the data, he expects some action by the physician directed at alleviation of the symptoms or troubles. Awareness of the patient's expectations is frequently expressed in medical circles by such statements as: "You have to give him something"—"The patient has a right to an ECG." However, there is insufficient awareness that the process of giving need *not* be in the form of a prescription, a laboratory examination, a special manipulation, or some magic formula for recovery. Many physicians are surprised to find that the patient considers adequate value to have been received by the doctor's attentive listening, understanding, and the offering of another appointment to discuss the problems in greater detail. Obviously there is need for a great deal of re-orientation about what the patient considers "value received."

It should also be obvious that a patient suffering from a severe migraine headache,

even though convinced that important elements of his problem are emotionally induced, may be far from satisfied with a promise of further study and exploration; he expects immediate or early relief. Behind the patient's provisional acceptance of the passive listening attitude of the therapist is an expectation that some process will ensue that will provide relief. The physician can put to good use this expectation which the dependent person displays. A child undergoes the experience that the laying on of a hand, a caress, a supporting arm around the shoulder, an attentive and sympathetic ear, or a kiss, takes the hurt away, or at least diminishes the pain. These healing responses are attributed by the child to the magic power of his parents and projected onto the doctor. The responses of approval, protection, sympathy and attention are sought as substitutes for the love and affection expected from parents. Threats, punishment and disapproval are also parental reactions which the patient may anticipate from the physician. By being a "good patient" he diminishes the risk of punishment and disapproval, and at the same time enhances the probability of recovery. Use by the physician of this type of relationship, however, carries with it the implication that a more mature and more responsibly adequate relationship cannot be established.

The physician's personality

The personality of the physician is an integral factor in the effects produced by all his treatment devices, whether additive, subtractive, or manipulative. The flexibility of the physician is an essential quality in the management of the patient. A physician may treat a patient in hypoglycemic stupor on the primary compliance level. When he becomes conscious, secondary compliance may characterize the patient's behavior. A more mature attitude with critical appraisal may be in evidence as the physician discusses possible exploration for a suspected pancreatic tumor. The following are but a few of the many personality traits which have significance for the physician in the management of his patients.

Rigidity and an unyielding nature, a preference for dealing with the patient on an intellectual level as though he were a physiologic object, and the avoidance of

involvement in the patient's emotional problems are qualities in the physician which significantly influence treatment—too often unfavorably.

Identification with the patient affects some physicians. Renneker, in studies of patients with breast cancer, found that the attending physician is often stirred deeply through identification with the dying patient. The desire not to be reminded of a previous traumatic experience may prevent an attitude of empathy which would be helpful in management. The undesirability of positive identification, as if the patient were a close personal friend or an intimate associate, has been sufficiently stressed.

Authoritarianism is a part of every doctor-patient relationship. The patient often needs and expects a certain degree of such control. Realistically, this should vary with the degree to which the physician's special knowledge makes it desirable that he make decisions for the patient. However, too many patients have strong feelings or passivity and dependency which drive them to extract a maximal degree of authoritarian control from the physician, and to avoid taking responsibility for self-management and self-control. They will react with anxiety and undesirable behavior if their needs are not recognized. Obsequiousness on the part of the physician toward persons supposedly in a prestige relationship to him may prevent development of the doctor-patient relationship needed for therapeutic effectiveness. It creates a situation in which the patient determines the therapeutic procedure. When passive, dependent traits are manifested by the physician, an atmosphere of doubt is created about the wisdom of his therapeutic procedures. Some patients with anxiety about retaliatory aggressiveness may, however, respond to treatment administered by the more passive type of physician with greater comfort.

The quest for certainty

This universal goal has a special poignancy in medical practice. It is present in the patient seeking help, whether for a physical or an emotional disorder; he brings to the treatment situation certain basic desires which Masserman has described as the basic defenses of man. In essence, the patient's defenses are: 1) a feeling of indestructibility; 2) a belief that others are in-

terested in him, even to the point of great personal sacrifice; 3) faith in some force or power, omnipotent and all-knowing, which in some way will protect him against danger. The physician is a representative of some significant figure from past experience. These essential defenses are utilized by the patient to find the required qualities in the physician. Awareness of the patient's needs for such defenses to help fortify him against anxiety and fear should be part of every therapeutic procedure.

Parallel with the patient's quest for certainty is the physician's comparable quest. Schwartz and Wolf expressed it as follows: "I may be useful in exploring the problems and treatment possibility for each patient to think in terms of certainty and uncertainty, or of realistic and unrealistic efforts to achieve certainty and how this concept plays a role in effecting therapeutic results. Our system of education seems to give the impression that for every question there is a single definite answer. Every patient likewise hopes for a single, simple, definitive cure. This is unfortunate because the problems encountered in later life and their solution generally cannot be answered quite so definitely."

The quest for certainty is the quest for an illusion. The patient's quest for certainty and his need for someone to help him even at a personal sacrifice distorts the image of the physician as a person when the patient is experiencing pain, distress, anxiety or fear.

Transference of attitudes and feelings

Transference is the term most commonly used to describe distortion of the doctor-patient relationship in psychotherapy. Rapport, confidence, acceptance, empathy, relationships, and many other terms are used to symbolize that interpersonal reaction which characterizes the contractual involvements of treatment. These phenomena are seen and can be studied as elements in any system in which one person seeks help and another offers help. In treatment, many of the patient's perceptions of the person caring for him express the need to see in the therapist the protecting or neglecting, the caring or the injuring roles of significant figures in his past. This repetitive tendency throughout life is an extension of the principle involved in the behavior of any or-

ganism—repetition of the adaptive patterns which earlier had been operationally successful. Infants and children endow parents with God-like magical powers. These same attitudes, expectations and powers are transferred by the patient in adult life to his transactions with the physician. Although such reactions are a necessary psychologic aspect of the patient's healing process, the physician must not accept at face value what the patient believes about him. Transference attitudes and feelings include:

1. Dependency needs, mobilized by stress of any kind, may be expressed realistically as a dependence appropriate to the disability, with recognition of the probable limits of a competent physician's ability to help. At the opposite extreme, these needs may be expressed unrealistically even to the extent of creating the expectation that the physician will give up his own interests in selfless devotion and accomplish for the patient what is beyond currently known medical science. The patient literally may want to remain in bed with all of his needs cared for, even to being fed and having bowel and bladder functions looked after by others. Dependency cravings may inadvertently be encouraged to flow from the acceptable social role during illness into a stage of regression that is malignant and nonreversible.

2. Denial of dependency by the patient is a defensive bravado, an ignoring of his anxiety. Such a defense may suddenly collapse into a state of acute panic or severe regression, to the surprise of all who accepted the defense at face value. The sick person may respond with combinations of the feelings and attitudes described under dependency needs.

3. Feelings of anger, resentment, and open hostility may be mobilized by unrealistic expectations. Thus, he may use the doctor-patient relationship to fortify a feeling of basic distrust.

4. Feelings of guilt may be manifestations of the patient's hostile and aggressive intentions.

5. Erotic feelings and shame may be aroused by undressing. Examinations and expressions of interest by the physician, especially with regard to the erogenous zones, may be interpreted as having an erotic motivation.

6. Feelings of envy and jealousy occasionally interfere with the realistic doctor-patient relationship; other patients may be getting better treatment.

7. Anxiety and fear may be aroused by transferred feelings related to anticipated punishment and withdrawal of approval producing concerns about a possible malevolent use of these powers in expressions of anger and hate.

The patient's perceptions of the doctor's office, the waiting room and other elements of his first introduction to the healer are colored by transference feelings. If the office is unusually crowded, the doctor becomes endowed with powerful magic; people must seek his help in such large numbers because he is so effective. If the patients are few, then it is implied that much time is consumed in the care of each, and the doctor must then limit his practice and show an unusual interest in each patient he admits. Each item in the office is used by the patient in this variable fashion to document what he wishes to believe about the doctor.

The physician's attitude toward the patient

Emphasis on a knowledge of self, so important in the treatment of patients with emotional illness, applies to the treatment of all patients. The physician needs to face maturely any strong feelings of like or dislike for his patient. Gerty wrote that the physician, in his devotion to his calling, may have to combat at times disliking the things he has to do. He must not dislike humanity, and must have some measure of charity and tolerance for its foibles, weaknesses, and prejudices. Our previous experiences contribute to the attitudes we develop toward our patients. Significant among all these are the conditioning experiences of our medical education. Stoller and Geerstma, in a study of student attitudes, found that medical students prefer to view even the emotionally ill person from the point of view of organic pathology. Anxiety mounts as they have closer contact and responsibility for mentally ill patients. This helps create the attitude that an organically ill patient is more desirable than the emotionally ill person. The physician, whatever his specialty, has the responsibility of learning about such personal attitudes

(positive or negative) toward patients. In this way personal and professional judgments may come closer to being harmonized for the welfare of the patient.

Countertransference is a term used for the physician's reaction to the patient, with feelings and attitudes similar to those he has manifested toward significant persons in his past. These are counterparts, in the physician, to the patient's transference feelings. Responses to patients which are expressions of countertransference are therefore not based upon the reality of the situation. They are attitudes which contaminate treatment. Guilt feelings may lead to treatment that does not go as far as it should, or that goes too far. An attitude of reserve may prevent adequate examination of the patient. Strong feelings of superiority may mobilize attitudes and feelings which have been described as "the God complex" by several authors.

Countertransference feelings are to be distinguished from those which are reasonable, realistic, and appropriate to the circumstances. A patient may be excessively demanding, rude and improper in his speech, manner and dress or in other ways behave unacceptably and offensively. The physician, as a human being, may react to such behavior with evident displeasure and non-acceptance. On the other hand, the physician's function in society realistically requires that he manifest a tolerant non-condemning reaction and an awareness that deviant behavior may be one expression of illness. The degree to which he can be objective, and react with understanding rather than with anger, impulsiveness, and retaliatory or overtly aggressive behavior is a measure of the physician's awareness of his role in society and the maturity of his relationship to patients. The patient's positive feelings of dependence, confidence, security, affection and overt intimate display may also arouse erotic feelings. It may be understandable that the patient sees the physician as a priest, a deity, or an adonis, but it is indeed an error in judgment for the physician to accept these attitudes as realistic. The physician's therapeutic focus and the interventions, which should logically flow from the relationship, readily fall into place. ◀

PATIENT ATTITUDE	THERAPEUTIC FOCUS		PHYSICIAN INTERVENTIONS	
Compliance	Cure and relief of symptoms. Relief of anxiety which then permits further exploration. Prevent recurrences—foster rehabilitation efforts	Always Emphasized	<div> <div>Asking questions</div> <div>Clarification</div> <div>Advice</div> <div>Reassurance</div> <div>Persuasion</div> <div>Suggestion</div> </div>	<div> <div>Rituals</div> <div>Magical instruments</div> <div>Magical potions</div> <div>Change of environment</div> <div>Non-verbal influences</div> </div>
Critical Appraisal	Cure and relief of symptoms. Increased adaptive capacity. Prevention of recurrence. Decrease severity and intensity of recurrence	<div>Important</div> <div>Where physician is expert</div> <div>Minimal use</div>	<div> <div>Asking questions</div> <div>Clarification</div> <div>Advice</div> <div>Reassurance</div> <div>Persuasion</div> <div>Suggestion</div> </div>	<div> <div>Interpretation of interpersonal attitudes and behavior, its genetic origins, and the transfer of past attitudes to present relationship with doctor.</div> <div>Non-verbal influences</div> </div>
Non-Compliance	Conversion of non-acceptance of patient role to one of acceptance. Proceed with therapeutic focus as for compliance or critical appraisal	<div>Directed at basic attitude</div> <div>When appropriate</div> <div>If expected to increase compliant or appraising attitude</div>	<div> <div>Asking questions</div> <div>Clarification</div> <div>Advice</div> <div>Reassurance</div> <div>Persuasion</div> <div>Suggestion</div> </div>	<div> <div>Interventions with aid of parent or guardian. Attention is directed toward the response to anticipated rejection, coercion or injury.</div> <div>Non-verbal influences</div> </div>

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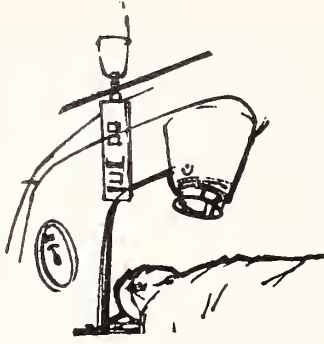
Anticipating the Census

The 1970 census will soon tell officially how many people there are in this country. Even without the census, certain facts are fairly well established about the country's population growth. For instance,

- Every 9 seconds someone is born in this country.
- Every 16½ seconds there is a death.
- Every 60 seconds an immigrant arrives.
- Every 23 minutes a citizen leaves to reside in another country.

The net result?

An addition to our population every 15½ seconds. This figure, extended, means four new citizens in just over a minute; over 232 per hour; and an increase of more than 5575 every 24 hours.



HARVEY KRAVITZ, M.D.
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Community

By LOUIS D. BOSHES, M.D. AND HANS W. KIENAST, M.D./CHICAGO

In the convulsive state, the complete control of seizures, by drugs or even by surgery is the ultimate goal. In epilepsy, more than with most diseases, the unit of treatment is first, the family, and then the community. In discussing the community problems related to epilepsy, one first must have a basic foundation concerning some of the concepts and the facts revolving around this symptom. Certainly, epilepsy is not a disease per se but refers to one or more of a symptom picture that is noted or even considered as a clinical entity. The word "epilepsy" is derived from a Greek preposition and an irregular verb; the combined word denotes the meaning of "to seize upon," "to catch," "to overtake," or "to lay hold of." This word has been in usage for many centuries and still describes a series or group of symptoms characterized by a sudden, involuntary, paroxysmal episode which tends to recur unexpectedly. This episode is also known as "a fit," "an attack," "a spell," "a convulsion," or even a "convulsive seizure."

The word "epilepsy" remains a terrifying sound to many people. Unfortunately, down through the centuries, prejudices and superstitions have accumulated heavily around this word. It is quite understandable that certain mysteries and fear are associated with a person who suddenly, with no evident reason, cries out, starts to twitch, convulses, lapses into a deep sleep and then, upon waking, reveals a dull and even blurred mental state. Even today, there are many who believe in witchcraft, feeling that persons with epilepsy are possessed by the devil. Many families are still burdened by this ignorance, stigma and prejudice. It is not uncommon for some segments of our population to make regular pilgrimages to holy shrines for the

alleviation of this symptom in the family member. Others come to their physicians asking for or are told that surgery must be done to remove the "devil." Appendectomies, herniotomies, circumcisions, or even "re-adjustment" or "stripping of the carotid" for alleviation of the seizure pattern, are still being done. Craniotomies are done in some parts of the world to break up a seizure pattern, and in a small measured percent this procedure is strangely successful.

Epilepsy in Childhood

Reaction between the convulsive state and the social environment is especially important in the young child with seizures. Environmental effects may thus become an

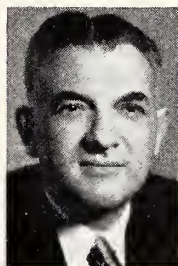
aspects of epilepsy

integral part of his makeup, his behavior, and his adjustment as he and his family attempt to maintain a respected and comfortable spot within the community. Certainly, this is dependent upon the frequency of episodes. There are some children who are unaware of any episode inasmuch as many of these may occur at night or perhaps they may be so mild and transient to cause only a very small or even an inconspicuous cessation of routine activity. Other children, however, are not as fortunate and eventually become fearful and dread an episode, which results in sudden and unprovoked embarrassment, and later in dullness of thinking following a major attack. As this child grows older, he may continue to experience more attacks to such a degree that he will be looked upon as unusual, peculiar, and certainly be dubbed as "different" from other children in his group. His only recourse then, is to accept this unhappy state, withdraw, become seclusive and selfconscious, with lack of any type of social intercourse with other children. Eventually, he may display other signs and symptoms denoting his continuing emotional stress, strain, and turmoil. Frustrating restrictions can only occur and

even worsen the child as routine expected competition continues in his growth and development. Eventually, as an adult, these same symptoms will remain and even continue as a responsible cause for unpopularity in the community.

Yet, there is a small group of children who have episodes, the etiology of which includes structural defects or injury to the brain. This child may suffer from physical and mental limitations characterized by mental retardation, visual and hearing defects, behavioral problems, and other symptoms, all manifestations of his condition of cerebral palsy. In spite of these handicaps, social acceptance for this child can still be obtained. A future is generally planned and assured for this child to include his education, his vocational guidance, and later, with proper rehabilitation, the certainty of a responsible place or even a role in his community. How much more fortunate is the child with cerebral palsy as compared to the one with epilepsy?

Obviously, parents of children with seizures may also feel stigmatized and have a sense of social ostracism. They may feel guilt or anxiety which is difficult to conceal from a child or from the community.



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In turn, then, this child tends to shun people, beginning first with his own family members. He will not accept parental attitudes of overprotection and overindulgence which later can only become complete rejection. Often there exist parents who are afraid, or even unable or unwilling to assume responsibility of planning or providing funds necessary for the medical attention for the guidance of an epileptic child. Still others are so poorly informed about assistance which is available that they will never seek it.

What, then, is the outlook for such a depleted child? With the present development of more concise and improved diagnostic measures, together with the advent of effective anticonvulsant drugs, the outlook for an individual with seizures is vastly improved. On the other hand, if the child is neglected, he has a disorder which can handicap him physically and emotionally. At the present time, and with our modern medical armamentarium, almost 80% of children suffering with seizures may respond adequately to treatment, 10-15% may be improved, and 1-5% remain stabilized. Statistically, there is conclusive evidence to show that the symptoms of epilepsy may cease or drop out over a period of many years and even be in a remissive state for many years.

Medical management alone cannot attain all the desired effects in complete control of the child's physical and emotional involvement. Prejudicial social attitudes must be overcome and removed to such a degree that the child with seizures may live, play, work, or operate in a normal competitive situation and become a contributing citizen within this community. Although there may be good medical management and satisfactory vocational guidance, an enlightened public opinion will greatly increase the opportunities for an individual with seizures.

For each individual, there exists a different combination of factors that sometimes defy evaluation. The type of seizure must be determined, the etiology, the age of onset, the management and its effectiveness, the physical, emotional, or even intellectual difficulties, and finally, one must learn the relationship of his family to the community. These are the constant variables which exist.

Incidence and Onset of Epilepsy

In this country, there are well over two million people with seizures. Local, state, and national surveys offer a basis for approximations of the incidence, but there are limitations to the data which are received. Reports may not be complete or accurate. There are some patients who are misdiagnosed and there are still others whose diagnosis is concealed. Fortunately, more and more people with seizures now seek treatment so that the numbers may increase. Figures as high as four million have been posed in some quarters.

As we know, epilepsy can attack all age groups, but seems most prevalent in children. Seizures are more commonly seen in the initial four years of life and the age of onset in 50% of the known cases is under 15 years. For this reason, early recognition and proper diagnosis is obviously vital. Good management must be offered in these developmental years to prevent severe psychosocial effects in later life which are bound to happen, under any condition.

It is noted that patients with epilepsy are appearing before physicians with increasing regularity and this may be due to the availability of better evaluation and management. On the other hand, more children survive illnesses due, perhaps, to modern medical management. Children with prematurity, developmental anomalies, birth trauma, severe infections, and head injuries now live longer with seizures so that statistics are more accurate.

Epilepsy is costly to society and there is a considerable expenditure involved in institutional care, amounting to many millions annually. Despite the fact that the largest percentage of patients with seizures need not be confined to institutions, a great proportion of those who live at home cannot attain regular employment. If the full impact of the finest rehabilitation services available were brought to bear on this large group, the economic contributions of those restored to society would be substantial and gainful.

There is no chronic medical condition more affected by the social condition of the patient than is epilepsy. Only alcoholism runs epilepsy a close second. Public misunderstanding not only hampers progress in developing services but forces some kind of unsatiable social climate in which a pa-

tient subject to seizures cannot expect to find acceptance or encouragement. Certainly, then, promotion of a better understanding and improvement of public attitude would be the primary goal of community service.

Professional Care and Assistance

The diagnosis of a patient with epilepsy can be somewhat difficult, and frequently involves the opinion of many specialists and certain complex diagnostic studies. Those skilled in the diagnosis and management of seizures are few and these physicians tend to congregate in large population areas or in university centers. Accordingly, there is a scarcity and an uneven distribution of needed professional workers and facilities in the rural areas. At the present time there is the Epilepsy Foundation of America, and through the efforts of this group, a much better liaison between the patient and the specific areas for his service demands are provided. Thus, these various sources can be mobilized with the community action to include:

1. Specific diagnostic facilities evaluation with periodic re-evaluation.
2. Medical management and health supervision.
3. Education on a regular or even on a special basis.
4. Vocational services, testing, counseling, training and ultimate placement.
5. Social work, mental health guidance and parent counseling.
6. Hospitalization, if needed, and institutional care, if required.
7. Recreational projects and facilities.

A variety of personnel is required to bring children and services together to carry out the different phases of management within a community. These key people include parents, physicians, nurses, teachers, social workers, psychologists and vocational counselors. Even religious leaders of the various faiths should be enlisted. To improve the matter of prevention, public education professional training, and research become other important features of a comprehensive community program. Such a broad approach, involving health, education, social and vocational resources, and a general directed attack by the citizenry, can aid through cooperative efforts, in the fulfillment of a bold and integrated plan.

The responsibility for seeing to it that children with handicapping seizures will receive adequate care rests upon specific individuals and special groups within any community. In the past decade, increased interest in the problems of seizures has been demonstrated and the ground-work for improved services is being laid constantly. Local, state, and national groups are recognizing epilepsy as a health problem requiring directed community action. At present there are certain programs cooperatively financed by the state and Federal Governments providing diagnostic treatment centers. Also, citizen groups have been organized to promote public interest in epilepsy. Even lay societies provide direct care for the individual. Professional associations, including those that I have mentioned, together with the "mother society," the American Epilepsy Society, and with the cooperation of medical societies, are in a favorable position to provide leadership and support in improving the quality of care required and offered to each individual with seizures.

Evaluation of the Epileptic

Most of the personal and social problems facing children with recurrent seizures are essentially the same as those facing other groups of handicapped individuals. Is there a special profile of an individual with epilepsy? Who is he? and What can he do? What can he be? Actually, an epileptic patient is not any unusual type of person. He may be found anytime and anywhere within the cross section of our society. From an economic point of view he may be poor, comfortable, even rich. Physically, he may be strong, weak, or even of medium strength. From the personality point of view, he may be attractive, non-attractive, indifferent, or even cantakerous. Upon this cross section of a person, then has been grafted a symptom which can be recurrent or which varies greatly in frequency and intensity. Differences exist, therefore, in the limiting factors for individual progress. If this person is a child, he may bring social and psychologic difficulties on to himself as well as to others around him, which may be unusually subtle, severe and continuous. One must probe deeply into the personal life of the child to observe all mental, social, economic, emotional and environmental factors involved. Such an evaluation also

implies an assessment of the positive factors which can be used constructively in promoting control of his seizures and later rehabilitation of the total physical structure.

The psychological appraisal should also be defined to facilitate selection of appropriate test procedures. A determination of the level and quality of a child's mental functioning should be made and this personality pattern response generally proves its value. A certain behavioral response may have a direct effect upon the child within his community.

It is important, then, to collect as much information as is possible in terms of recommendations for home and school management, the later educational placement, the vocational goals, and if necessary, referrals to psychologic, psychiatric, or social service studies must be made.

It is important to investigate the patient's early social history, growth and behavior, intellectual capacity, capabilities, and limitations, as well as his feelings and attitudes about his own seizures. One must collect information from the patient's family and home to include cultural, psychologic, and social factors. Also, the past history must be evaluated carefully, particularly to include parental and sibling feelings toward the child's seizures. Apart from the home environment, one must learn the aspects of the community in which the child with epilepsy lives. Here should be ascertained the attitudes of the neighbors, school, teachers, religious leaders, camp groups, social clubs and the Boy Scouts, concerning the youngster's seizure state. Well known are the experiments of the two-month vacational periods at a camp in St. James in Normandy, where complete physical, neurologic, psychologic, and laboratory studies are made on children in a relaxed atmosphere. There is careful integration of medical, psychologic, and social factors which are evaluated during the time the children are in camp. Similar experiments are being conducted at the Epilepsy Centre in "Meere en Bosch," in Heemstede, the Netherlands, under the aegis of Dr. A. M. Lorentz de Haas. Dr. J. C. Bowe has developed such a school in Lingfield, Surrey, England.

Again, a psychosocial appraisal of any child who has seizures should be concerned with the following important questions:

1. What are his specific personality characteristics?

2. How good is his emotional adjustment to his seizure picture?
3. How do seizures affect his personality and psychologic equilibrium?
4. In what way are the seizures affected by his psychologic problem?
5. What factors other than the seizures account for any disturbance in his behavior or emotion?
6. Does the child have personality strength or attributes to assist him?
7. What does the child think of himself as one who has "spells?"

Public feeling and misunderstanding about epilepsy have produced in many communities an unsatisfactory social milieu in which to bring up children with seizures. Earlier it was stated that epilepsy is still associated with superstitions in certain cultures. Unfortunately, society has tended to classify all epileptic patients together, considering them as pitiful, incurable individuals who require isolation.

Over a period of some 25 years, Drs. William F. Caveness and H. Houston Merritt, inspired by the interest of the late Dr. William G. Lennox, have made a survey in conjunction with Dr. George H. Gallup, to evaluate current trend of opinion and public attitudes toward epileptics. A series of questions was formulated by Drs. Lennox, Merritt, and Caveness to include matters such as familiarity with epilepsy, objections of children playing with epileptics, whether epilepsy is believed to be correlated with insanity, and the question of employment in epilepsy. There is no question that there has been an improvement in the epileptic lot and it is apparent, too, that this trend is continuing. These latest are most encouraging from the point of view of the individual and his region of the country.

Service and facilities must be provided for those who have seizures, which explains in part the difficulties lay groups encounter in stimulating or organizing community support of an epilepsy program. To meet full responsibilities for children under their care, even well informed professional persons should examine their own attitudes toward epilepsy. They should also seek more opportunities within their communities to correct misconceptions or ideas of the seizure state and to help broaden knowledge to contribute to better understanding. This may be done through pro-

fessional conferences and meetings, case presentations, journals, exhibits, and through the channels of radio and television. Dissemination of this information must almost become a public duty at all times.

Attitudes of the Patient

How does the patient feel about himself? When asked to define, describe, or explain epilepsy one might answer, "I hate to even use the word," "It's nasty," "It's a scar on my brain," "It can be controlled," "It cannot be controlled," "I'm different than I used to be," or "I'm irritable and cranky." Some would like to become leaders in their community but fear that public knowledge of their seizures would alter or jeopardize their leadership. Others will tell their employer about the seizures, but no other employees. Others tell no one at work of their plight.

Because of his seizures, a patient may not engage or participate in the usual family activities. In an effort to "protect" her husband, a wife will often hide the fact of his seizures from the children; she might say, "Your father has been drinking again, that is why I put him to bed." Obviously the father had just had a seizure.

Many patients describe themselves at work as functioning in an atmosphere of continued fear that they will be discovered and their condition will be revealed. They wish to get out of sight when a seizure is impending. Others may express the fact that they would be better off in a new job with more money and more responsibility as an excuse to leave a job once the seizure state is discovered. This involves additional stress and strain and may cause more seizures to appear. Hence, they do not seek such jobs, and prepare to ride out one storm in the old place of employment. Others will state they would have better jobs and might have been promoted, but they lost their jobs because of their seizure state being discovered one day while at work.

Social Attitudes

There are many individuals with seizures who are unable to accept themselves as worthy individuals and under these circumstances, the community is expected to do and feel the same. Some will refuse to run for public office inasmuch as they fear

they will be judged harshly because of their seizure state. Still, others are afraid to adopt children because a social agency may refuse or even deny an application. Many will live with their feelings and find a place for themselves in society at their own level. In brief, the cause of these attitudes is summed up in this way—what a patient doesn't know, he fears. What people don't know, they fear. Since people know little about epilepsy, they fear it. In the face of fear and hostility of the world, many may reply in kind. The problem must be solved as others have been—by making known to the people of the community its significance. Epileptic organizations must be started, implemented, and directed in a multidisciplinary fashion to survey the needs which include diagnosis, treatment, education and eventually the employment of people with seizures. These groups should have medical advisory committees serving as liaison with the groups within the city. By the same token, there should be educational coordinators. There are certain areas in city governments in which such studies are done regularly and routinely so why not have the same for an epilepsy group?

Public attitudes directed to the patient who is epileptic must be changed in many communities and even in certain states. It is just as important for a physician or rehabilitation counselor to spend some time in educating the public as it is to see another patient in his office or in the clinic.

Epilepsy Program within the Community

How then does an epileptic program begin? Usually within a community there are some successful professional or businessmen who have seizures, or who have someone within their family so affected. At first, only a small group cadre is formed, but others will follow later. An example is given of 40 people who appeared in Baltimore, Maryland, at an initial meeting called by a voluntary agency on seizures, where it was found that 39 of the charter group had seizures. This is seen regularly and even expected.

Health departments in counties, cities, and states may be of great help in disseminating specific information about seizures. Often churches are not included but should be involved for they are excellent areas

from which to disseminate knowledge. Community aspects vary with the individual's interest, but betterment of the group is found when a man who has a disability joins in with other men who have no disabilities. Such a group also helps prepare the disabled as a better citizen.

Dr. Raymond Denneril, executive director of the Michigan Epilepsy Center says, "There are no authorities in public attitudes in the field of epilepsy." What exists at present, he states, are opinions of people with varying types of experiences and backgrounds. More authoritative research with regard to current attitudes is needed because knowledge grows with interest that mounts.

Management of the Seizure Patient

Every person with seizures who is placed in a job should be carefully selected and realistically guided to include specific contact with his employer. The vocational counselor, by spending a good deal more time with the individual with seizures, can make him a far better employee. Unfortunately, many epileptics must have jobs obtained for them because they feel they are poor candidates when employment is sought individually. They feel that businessmen are "realistic people who know all the facts." But many businessmen do hire such patients, particularly if seizures are present in someone within their own family. On the other hand, the employer working with the epileptic can be a rejecting factor. Once an epileptic is hired, he may be protected by others in the plant or factory so that the employer will not know about the episodes.

In the recent past, there has been dispelled much of the negative attitudes toward such diseases as tuberculosis, heart disease and syphilis. Why not the same, then, toward epilepsy? Every negative and positive attitude should be discussed with every employer. When presenting the truth to a prospective employer, there should be no defensive attitude. Presently, in several cities, special lay groups have approached

many giants of industry and have mobilized members of medical advisory boards to speak professionally to these executives.

The Illinois Epilepsy League is presently embarked on such a campaign. At the same time the personal physician within the community must be knowledgeable about the individual's seizures. In other words, although there are admittedly, highly emotional problems existing in a patient with seizures, they must be treated thoroughly within the scope of the total approach.

With the new impetus and the matter of thorough diagnosis, through examination and management, there is more and more diminution in the incidence of emotional presentation. Ideally, no one with seizures should be denied the advantage of education, the right to marry, to beget children, to drive a car, to hold public office, or obtain insurance, all because he has an occasional seizure. One should not single out a patient with epilepsy as being "different." Considerable public education is then necessary to have the individual with seizures accepted with the same composure accorded to those afflicted with diabetes, tuberculosis, heart trouble or cerebral palsy. Severe restrictions are not necessary in the lot of the epileptic who carries his heavy load anyway.

The late Dr. William G. Lennox stated, "Behind the mechanism of seizures lies the subtle attributes and the vicissitudes of each individual epileptic. To clarify remaining mystery about seizures and to succor persons subject to them is a long-standing obligation that must be redeemed by physicians, brain scientists, or by men and women of good will."

Surely, the men and women of good will exist in all of our communities and are ready to play the part in the home, school, factory, office, camps, clubs and lay organizations anywhere. They can be mobilized at any time to assume this obligation, but their role must be a continuing one if it is to be successful. There can only be success with the understanding attitude of the community to the individual who has a symptom called "epilepsy." ◀

Pollution Control Spending Peaks

Pollution control spending rose 23% in 1969, to a record of \$256 million among 248 companies, according to a survey by the National Industrial Conference Board.

An analysis Of 500 consecutive cases Of acute appendicitis In a metropolitan Charity Hospital

BY SUSHIL M. SETHI, M.D., TAKAYOSHI MATSUDA, M.D., L. BEATY PEMBERTON, M.D.,
AND E. LEE STROHL, M.D./CHICAGO

Introduction

Acute appendicitis continues to demand the surgeon's ingenuity and judgment, and remains a significant cause of death, especially in the very old and very young. Kelly and Watkins¹ attributed the mortality of acute appendicitis to three contributing factors: 1) delay in seeking medical attention; 2) home treatment with laxatives; and 3) difficulty in diagnosis. The mortality rate from acute appendicitis declined progressively from 3% in the middle 1930s to 1.92% between 1937-39, and finally to 1.48% during the period 1939-45.^{2,3,4}

Although surgeons have improved patient care by advances in sterile technique, fluid and electrolyte replacement, and use of antibiotic drugs, early surgical intervention

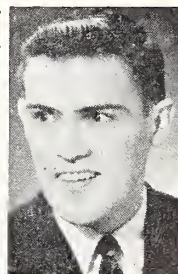
remains the most significant factor in maintaining a low mortality rate for acute appendicitis.⁵ During the last two decades, further progress has been made in educating the lay public in regard to acute appendicitis, and in alerting physicians to the need for early diagnosis.^{6,7} Therefore, being aware of these past contributions and the continuing clinical problem, we decided to study the patient population of a charity hospital, with poor general health, of the low socio-economic group, to re-assess the present diagnosis and treatment, as well as to review the mortality of acute appendicitis in these patients.

Clinical Material

The 1964-65 records of 500 consecutive and unselected patients having acute appendicitis at Cook County Hospital, Chicago, were reviewed. Patients with inciden-



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tal appendectomies or normal appendices at abdominal exploration were excluded from the study.

The greatest incidence of acute appendicitis occurred between the ages of five and ten, with almost half of all the patients between 5 and 15 years of age. There were 259 children and 241 adults, with only 42 patients over 60 years of age. (Table 1)

Table 1

Age	Distribution of the Patients	
	Number of Patients	Percent
0-5	26	5.2
5-10	120	24.0
10-15	113	22.6
15-40	111	22.2
40-60	88	17.6
60-70	32	6.4
70-	10	2.0
Children	259	
Adults	241	
Above 50 Years	120	
Youngest	6-months-old	
Oldest	91-years-old	

Various symptoms and their duration are tabulated in Tables 2 and 3. Although a majority of patients (62%) sought medical care in the first 48 hours, a large number of patients (95, or 19%) presented to the hospital more than 72 hours following the onset of symptoms. In addition, the high proportion of patients with pain, anorexia, nausea and vomiting, confirmed the usual symptom complex of this disease.

Table 2

Complaint	Significant Symptoms	
	Number of Patients	Percent
Anorexia	444	89
Nausea	424	85
Vomiting	427	85
Pain	492	95
Constipation	50	10
Diarrhea	42	8

Table 3

Time (Hours)	Duration of Symptoms	
	Number of Patients	Percent
0-12	56	11.2
12-24	185	37.0
24-48	125	25.0
48-72	39	7.8
72+	95	19.0

The majority of patients (68%) were taken to surgery less than six hours after admission. Only 4% required more than 24 hours of observation to establish the diagnosis. Furthermore, while 29% of the patients received two to four liters of fluid, most patients (71%) were given less than one liter of fluid prior to surgery.

The management of these 500 patients demanded flexibility in the surgical pro-

cedure. Although most patients had general anesthesia, eight patients were operated under spinal anesthesia, and two with local infiltration. The usual incision was the McArthur-McBurney muscle-splitting incision.⁹ In addition, while ten patients had drainage for appendiceal abscess, the other 490 patients were treated with appendectomy. Following appendectomy in the patients, 261 patients had no drainage or antibiotic drugs; 76 had subcutaneous drainage with no skin closure, and 153 received peritoneal drainage.

The post-operative therapy of these patients involved intravenous fluids, antibiotic drugs, nasogastric intubation, and treatment of wound infections. Intravenous therapy was required in 259 patients for 48 hours; in 168 patients for 72 hours; and in 73 patients for more than 72 hours. Antibiotic drugs were given to 157 patients, usually for perforated appendices. Although chloramphenicol, streptomycin and other broad spectrum antibiotic drugs were used, penicillin was the most frequently employed antibiotic drug. Nasogastric intubation was used in 275 patients to treat or to prevent abdominal distention. Finally, 60 patients had wound infections or intra-abdominal abscesses which required subsequent drainage.

The final pathological report was as follows: acute appendicitis without perforation in 323 patients, and acute appendicitis with perforation in 167 patients. The ten patients with appendiceal abscess had no report because the appendix was not removed.

The average hospital stay was 6.8 days. Nevertheless, 163 patients required ten or more days of hospitalization for associated medical problems or post-operative complications.

The mortality was eight deaths out of 500 patients, or 1.6%. All deaths occurred in adults. After searching our records, we found that the last death in a child from acute appendicitis, at Cook County Hospital, Chicago, occurred in 1961. The cause of death in the eight patients who died, was overwhelming sepsis in four patients, and one patient each with acute renal failure, upper gastrointestinal bleeding and hepatic failure, massive upper gastrointestinal bleeding, and pulmonary infarction.

Further analysis of the deaths revealed that six of the eight deaths occurred in 120

patients over 50 years of age, a mortality rate of 5%. (Table 4) Four deaths occurred in the 42 patients over the age of 60, for a mortality rate of 9.5%. On the contrary, the mortality rate in patients below the age of 50 was 0.52%.

Table 4

Analysis of Deaths (Total Number: 8)		
1—Race and Sex		
	Negro Male	2
	Negro Female	3
	White Male	2
	Spanish Male	1
2—Age		
	70 years and older	4
	50-60 years	2
	40 years	1
	20 years	1
3—Duration of symptoms prior to admission		
	24-48 hours	4
	48-72 hours	1
	More than 72 hours	3
4—Cause of death		
	Generalized peritonitis with overwhelming sepsis	4
	Acute renal failure	1
	Pulmonary infarct	1
	Hepatic failure, ascites and upper GI bleeding	1
	Massive upper GI bleeding	1

Discussion

In spite of improved education of the lay public, many patients had a long delay between the onset of symptoms and arrival at the hospital. Such a delay increases the number of ruptured appendices and deaths. All of our deaths occurred in patients who were admitted to the hospital more than 24 hours following the onset of symptoms. Five of the eight deaths occurred in patients admitted between 24 and 48 hours after the onset of symptoms, and the remaining three deaths occurred in patients admitted after more than 72 hours of symptoms.

In those patients who present in the late stage of the disease, careful assessment and optimal pre-operative restoration of cardiopulmonary, hemodynamic and renal function is mandatory in successful surgical therapy. Management of hydration is a challenge in some patients, such as those with congestive heart failure, or cirrhosis with ascites.

An early diagnosis which leads to prompt surgical intervention is essential for effective management of acute appendicitis. Confirming the diagnosis of appendicitis is not easy in atypical cases. In our patients, pelvic inflammatory disease was a most perplexing problem in young females. Various laboratory adjuncts, such as white cell count, urinalysis, and abdominal X-rays,

were sometimes helpful, but there was no single definite diagnostic test for acute appendicitis. In our experience, careful observation with frequent re-examination of the abdomen is the most important diagnostic tool.

The value of antibiotic drugs in managing acute appendicitis and its complications is difficult to evaluate. While three of the eight patients who died in this series received pre-operative antibiotic drugs, all of these patients received these drugs in the post-operative period. Overwhelming sepsis accounted for half of the deaths in this study. Thus, on a theoretical basis, some of the newer broad spectrum antibiotic drugs that are particularly effective against gram negative and anaerobic bacteria should improve the treatment of infections secondary to appendicitis.

Summary and Conclusions

In spite of education of the lay public and advances in surgical management, the mortality of acute appendicitis remains comparatively high,¹⁰ especially in elderly patients. Five hundred (500) consecutive patients with acute appendicitis, at Cook County Hospital, Chicago, during 1964-65, have been reviewed in an attempt to re-evaluate present treatment, as well as to review the mortality of this disease in a charity hospital. An overall mortality of 1.6% was observed. There were no deaths in children. However, a 5% mortality was found in patients over the age of 50 years, and 9.5% over the age of 60. Most of the deaths occurred in patients with ruptured appendices who presented in a late stage of the disease. A more aggressive approach to the surgical management of acute appendicitis should improve the overall mortality rate. ◀

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(Continued on page 178)



Membership Forum

June 15, 1970

Gentlemen:

I talked with someone in your organization on the phone Friday about an article on Hodgkin's disease that I wanted to get a reprint of, and it arrived at my home Saturday Special Delivery.

Thanks very much for this prompt and excellent response.

Sincerely,
W. J. Wichman

April 22, 1970

Dear Dr. Van Dellen:

The article "What Generation Gap"? (*IMJ*, Feb. 1970, Vol. 137, No. 2, pages 168-171) prompts the following. Dr. Eisele's interpretation seems to be contrary, in some instances, with the survey data. Also, the construction of the questions does not appear to be an entirely impartial approach to the subject.

However based on the questionnaire used and the responses, I could not resist writing the way it looks to me.

Sincerely,
Alfred W. Hubbard
Director of Research
Modern Medicine

The *Illinois Medical Journal* survey of attitudes and opinions of established practicing physicians, students, interns, and residents indicates that there is little medical generation gap. There is a reasonably good agreement between the future doctors and the established doctors on subjects relating to medical proficiency, relicensing, and so on. But, on socio-medical issues the generation gap is substantial and readily apparent.

When one-fifth to three-fourths or more of the future doctors disagree with the established doctors on some important items, then the medical profession does face a serious generation gap. It would appear that this substantial proportion of America's future doctors really is bent on revolutionizing the socio-medical aspects of health care. The shout of this large percentage of future doctors is really an imposingly demanding voice of the future physician.

Nearly three-fourths (+71%) more of interns and residents and about double the proportion (+92%) more students than established physicians favor the hiring of trained and licensed "doctor's assistants" or "feldshers" to work in his of-

Ed. note: Membership Forum is a means for the ISMS physician to express opinion and viewpoint on varied topics. If you have an item you would like brought before your fellow practitioners, please submit it to Membership Forum, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601. Communications should not exceed 250 words. The right to abstract or edit is reserved. Names will be withheld upon request, but anonymous letters will not be accepted.

fice, performing such tasks as preliminary screening for illness, well-baby examination, and family planning.

Two-fifths (+43%) of interns and residents, and over one-half (+54%) more students than established doctors favor having the state medical society lend financial support to the establishment of health centers in deprived areas.

Survey respondents feel that interns and residents should supply the manpower in health centers by four-fifths of the established doctors to only one-fifth of future doctors. Among interns and residents, there are nearly one-fifth fewer who agree with this, or, a two-thirds to one-third proportion. Among students it is 8% fewer or three-fourths to one-fourth who agree with the established.

Only one out of ten students and nearly two out of ten interns and residents disagree with the proposition that the ISMS should initiate an educational campaign to liberalize therapeutic abortion. It is nearly one out of four for the older doctor of 8% more interns and residents and 17% more of the students than established feel the law should be liberalized. Nearly the same ratios are evident in the case of legislation providing medical care for arrested chronic alcoholics as a medical problem.

An examination of the situation for other propositions will reveal further differences. However, it can be noted that both the future doctors and the older established doctors appear to close ranks when it comes to questions on qualifications, proficiency, discipline, postgraduate education, relicensing, or the "medical" oriented subjects. There is very little medical generation gap in the approach to thinking by either.

It is not so much a "medical" generation gap as it is a "social consciousness" gap between the youth of the future doctor and the age of the established doctor. The medical establishment cannot simply shrug it off. The message the medical

youth generation is putting forth is that things are changing. The establishment had better "get with it," think, plan, and do more in social medical assistance for the sick-deprived.

To interpret what the youth—future doctors—are saying is: the physician has responsibilities as an educated person aside from his role as a physician. He should participate in the total social, cultural, educational, and health life of the community.

As a physician he has a special area of responsibility to know the health needs of his own community. He should be willing to plow back some of his income via the medical society dues and

assessments to improve standards of public health. He must exert pressure for health centers for the deprived. He must stand up and be counted for improvement in the quality of local nursing homes. Also in addition to his immediate responsibility to his own local community, the physician is now obliged to become knowledgeable and active in the broader aspects of national involvement in health care. It is also the physician's responsibility to look to the future and anticipate health needs at both local and national levels.

There is, indeed, a generation gap between the future and established doctors. This gap chiefly concerns social consciousness. AWH

Medical Controversy

The principal conclusion from events of this past year is that medical students are strong-willed; some are able to spend large amounts of time on extra-curricular concerns and still keep their academic work up to par. They are imbued with an immense social consciousness (far greater than most of us at that age), and many of them, whether silent or noisy, minority or majority, want to help. If action and protest are to assist the medical mission to the sick, they must address themselves to at least one of the major problems that obstruct that mission today. Although it would be presumptuous for any one doctor to catalogue all the ills of medicine, or recommend treatment, the following is a list of 10 major concerns in 1970:

Care of the Sick

- 1). Facilitate energy into the system for all who need it.
- 2). Lower the cost of service by increasing efficiency, improving administration and decreasing waste.
- 3). Arrange payment so that the patient is not penalized for the severity of his illness, over which he has no control.

Education of the Physician

- 4). Shorten the duration of medical education (college to practice) by one, two, or three years.
- 5). Remodel the curriculum so that career-patterns can determine content and courses are relevant to need, yet without premature specialization.
- 6). Lower the cost by new teaching methods; meet those costs by a merit scholarship system attracting talent without penalizing poverty.
- 7). Expand the content of medical education so that a new generation of more able physician-administrators will improve rather than merely deplore the cost and delivery-systems of American medicine.

Biomedical Research

- 8). Expand objectives of medical research to include a rigorous study of social goals and delivery systems.
- 9). Initiate a more rigorous quality control, with better selection of recipients for the tax-based research support.
- 10). Expand the sources of research support to tap all segments of society and all political units. (Francis D. Moore: West of Francis Street—Can Student Pressures Assist the Medical Mission?, *New England J. Med.* 282:18 (Apr. 30) 1970, pg. 1008-1013.)



THE DOCTOR'S LIBRARY

CONTRIBUTIONS TO CLINICAL NEUROPSYCHOLOGY. Edited by Arthur L. Benton, Aldine Publishing Company, Chicago. 1969; 243 pages, several tables.

This small volume provides a concise, definitive, up-to-date compendium of present information on clinical neuropsychology, which is relatively a new science not more than 20 years old. This discipline utilizes clinical research studies and animal experimentation together with developmental observations to fulfill its purpose of defining the relationship between brain function and human behavior. Obviously, quite a number, as well as a variation of scientific areas, must be present within this aegis.

Some eight authorities, each versed in his special area of Neuropsychology discuss their specific contributions to this little volume. The chapters are entitled 1. Modern Trends in Neuropsychology, 2. The Behavioral Effects of Commissural Section, 3. Neuropsychological Studies of the Phantom, 4. Problems in the Anatomical Understanding of the Aphasias, 5. Constructional Apraxia: Some Unanswered Questions, 6. Protopathic and Epicritic Sensation: A Reappraisal and 7. Auditory Agnesia: A Review and Report of Recent Evidence. Each of these subject titles is geared to its relationship to behavioral syndromes, which are the end products, clinically.

This book holds great value for, and is indeed a useful tool to, the Clinical Neurologist in the adult or childhood field, for the psychiatrist to adults or to children, to speech therapist, to the physical, occupational, and play therapist. The material is so well structured and constructed and so easy to read and comprehend in the areas of aphasia, apraxia, agnosia, dyslexia, language retardation, that it can be easily utilized by these disciplines. Finally, an excellent set of tables in each chapter, with a more than adequate Reference List, at the end of the book, more than enhances its usable values.

Louis Boshes, M.D.

THE PULMONARY CIRCULATION AND INTERSTITIAL SPACE. Alfred P. Fishman and Hans H. Hecht, 432 pages, illustrated. \$15.00. London and Chicago: The University of Chicago Press, 1969.

This volume on the pulmonary circulation and interstitial space is an outgrowth of the Satellite Conference in the Pulmonary Circulation held in Chicago in the Fall of 1968. Outstanding investigators presented and assessed the current status of the knowledge of the pulmonary circulation and the interstitial space. The manuscript and discussions presented at the conference comprise the volume.

There are four sections: 1) pulmonary alveolar-capillary interface and interstitium, 2) vasomotion and electrophysiology of smooth muscle, 3) regulation of pulmonary circulation and, 4) pulmonary hemodynamics.

The contributors represent physiologists interested primarily in the pulmonary circulation, as well as those interested in muscle physiology, bioengineering, transcapillary exchange, etc. so that good interdisciplinary interchange is represented. Throughout, structure is related to function and to the newer concepts in the various fields.

The volume itself is handsomely produced and the illustrations and charts are of the highest caliber. Unfortunately, the test material and its presentation are so sophisticated that only a limited audience will appreciate its value. As a consequence, it will exist essentially as a reference volume for those interested in the basic physiologic aspects of the pulmonary circulation.

Thomas W. Shields, M.D.

CARDIOVASCULAR SURGERY, CURRENT PRACTICE. Edited by Thomas H. Burford and Thomas B. Ferguson.

This well constructed book of 250 pages is organized in a very logical form, whereby the earlier chapters are discussions of general topics which include Chapter 1,

whole-body perfusion and in Chapter 2, the over all postoperative care of the open-heart patient. Chapter 3 is a supplement to the second chapter on postoperative care, dealing primarily with respiratory support. These three chapters of the book are exceedingly enlightening, and would be an excellent fundamental background for any surgical resident, and especially a surgical resident who plans to perform cardiothoracic surgery. If the book contained only these three chapters, it would be a worthwhile addition to any surgical library.

The fourth chapter, which deals primarily with tetralogy of Fallot, is an excellent chapter on this particular congenital anomaly. However, I believe it presents the weakest link of the book in the respect that there is no consideration given to the remainder of the problem of congenital heart disease and its surgical treatment in the neonatal and infancy. The text then does have a void in the current practice of cardiovascular problems in infants and children, excluding the tetralogy of Fallot.

The following two chapters which cover the problem of valvular surgery are very

informative, well organized and cover both the prosthetic valves, as well as homografts. The chapter on myocardial revascularization is likewise informative and outlines the historical background of coronary artery surgery and brings it up to date, with the closing portion of the chapter suggesting that the results of coronary artery surgery are still incomplete because of short follow-up and that further development along the lines of vein bypass may or may not prove to be more productive.

The final chapters on cardiac transplantation and left ventricular assist devices are both interesting and informative. The application of cardiac transplantation is perhaps somewhat optimistic, but certainly deserves further inspection and continued research. Likewise, the chapter on ventricular assist devices is somewhat restricted and unilateral, but is a good introduction to the entire problem of ventricular assists and its role in cardiac surgery.

In reviewing this book I have found it most stimulating to read, easy to read, and would consider it a real asset to the surgical library in any training institution.

Arthur DeBoer, M.D., S.C.

Man, A Howling Monkey?

Man probably descended from a primate that used its limbs for grasping and hanging in much the same way that the South American howling monkey (*Alouatta palliata*) now does, according to Jack T. Stern, Jr., instructor of anatomy, in The Pritzker School of Medicine at The University of Chicago.

Stern's theory is based on the fact that the muscle structure and bone-muscle relationships of the human hip are more similar to the hip of the howler than to the hip structures of any other type of primate.

"Man probably evolved from a species that was physically ready to walk on the ground," Stern said. "The hip musculature of evolving man would have required the least reorganization had he descended from a primate employing its hind limbs for slow climbing and suspension as does the howler.

"Since there is a direct relationship between the structure of an animal's limbs and its method of locomotion, the logical way to hypothesize about 'preman's' style of movement is to observe the movements of the tree dwelling primate with muscular and skeletal structures most similar to those of man," he said.

The examination of 18 species of South American monkeys and specimens of several kinds of Old World primates revealed that the species with a hip structure most like modern man is the howling monkey.

This does not mean, however, that the howler is an ancestor of man, Stern emphasized. All evidence indicates that the South American primates were separated from the Old World primates, from which man evolved, between 40 and 50 million years ago—long before man appeared.

"Furthermore, the howling monkey has a prehensile tail. Man more likely evolved from a primate with a reduced or absent tail.

Illinois adopts Anatomical Gift Act

BY FRANK PFEIFER, ISMS LEGAL COUNCIL/SPRINGFIELD

Illinois has adopted a new Anatomical Gift Act which, while differing somewhat from the Uniform Act on this subject, is a great improvement over the one previously in force.

Under this Act, which is set out in Paragraphs 551 through 561 of Chapter 3, Illinois Revised Statutes, 1969, the gift of all or any part of the body may be made by the donor during his lifetime or by his next of kin after his death. In the case of the gift by the living donor, the document making the disposition of all or any part of the body must be signed in the presence of

two witnesses, in much the same manner as a will is executed.

The American Medical Association has a form to be used by the living donor under the Uniform Act but this form is not legal in Illinois and therefore should not be used by any resident of Illinois.

The Illinois State Medical Society and the Illinois Hospital Association, after the adoption of this new Act, which repealed the old Act on this subject, devised forms for both types of gifts, together with instructions as to the manner of filling out the forms, copies of which are as follows:

Anatomical Gift By a Living Donor

(1)
I, _____, do hereby give
(2) _____ to
(3) _____ for the following
(4) purpose: _____

IN WITNESS WHEREOF, I have hereunto set my hand
(5)
and seal this _____ day of _____, A.D. 19_____
(6)

(SEAL)
Signed, sealed, published and declared by the said
(1) _____ in the presence of us,
who at his (her) request, in his (her) presence and in
the presence of each other have hereunto subscribed our
names as attesting witnesses, believing him (her) to be of
sound and disposing mind and memory, free from any
undue influence, and to know the objects of his (her)
bounty and affection.
(7)

(7)

Instructions

1. Insert name of person making gift.
2. Insert: "my whole body"; or list specific organs and parts to be given.
3. Insert name and address of a physician; or a hospital, or a medical institution to receive the gift.
4. Insert: "any purpose authorized by law;" or "a transplantation" or "therapy;" or "research;" or "medical education."
5. Insert date of the signing of this card.
6. Signature of donor.
7. Signature and address of two necessary witnesses.

Anatomical Gift by Next of Kin Or Other Authorized Person

- I. I (we) are the surviving:
1. ☐ Spouse and adult sons and daughters
 2. ☐ Both parents or surviving parent

3. ☐ Adult brothers and sisters
4. ☐ Guardian of the person of the decedent
5. ☐ Person authorized or under obligation to dispose of the body

of _____, who died on the
_____ day of _____, 19____ in the County
of _____, State of _____;
and

II. I (we) hereby give:

- ☐ The entire body of the deceased.
- ☐ Any specific organs or parts of the body of the deceased designated by the donee.
- ☐ The following organs or parts of the body of the deceased:

TO:

(Insert name and address of a physician; a hospital; or a medical institution)

for one of the following purposes:

- ☐ Any purpose authorized by law.
- ☐ A transplantation.
- ☐ Therapy.
- ☐ Research.
- ☐ Medical education.

III. I (we) hereby represent and certify that I (we) are the person(s) authorized to execute this authorization in accordance with the order of priority specified in the Uniform Anatomical Gift Act as listed in #I above.

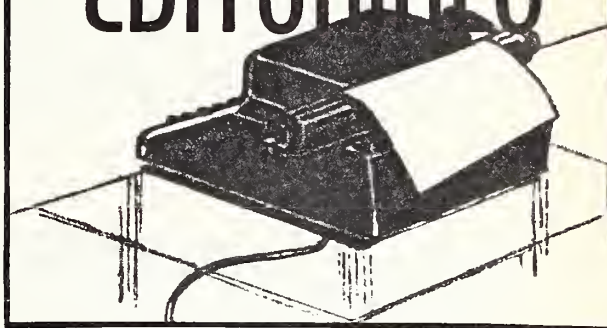
Name	Relationship to deceased	City & State
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Instructions

This form must be signed by the survivor or survivors in the order of priority, Nos. 1 through 5, with all persons in any category being required to sign. (EXAMPLE: Form to be signed by living spouse and all living adult sons and daughters; but if no survivors in this category, then go to No. 2 under which surviving parents or parent must sign but if no one in this category, go to No. 3, where all surviving brothers and sisters must sign; and in the same manner through Categories 4 and 5 if necessary.)

If additional signature lines are needed, they may be added at the bottom of the form.

EDITORIALS



PROGRAMMING THE MEDICAL COMPUTER

There is considerable difference between the interpretation of medical terms by the physician and his patients. Charles M. Boyle,¹ a final year student, University of Glasgow, prepared two multiple choice questionnaires that included such commonly used terms as arthritis, heartburn, palpitation, stomach, and kidneys. The questionnaires were completed by 234 out-patients and compared with those completed by 35 physicians.

"The doctors were unanimous in their choice of definition for 7 of the 12 terms—'arthritis,' 'heartburn,' 'jaundice,' 'palpitation,' 'bronchitis,' 'piles,' and 'flatulence.' They reached a level of agreement of over 90% for 'least starchy food,' 'a medicine,' and 'a good appetite.' 'Constipation' was defined as 'not opening one's bowels every day' by 11.4% and 'diarrhea' as 'passing a lot of bowel motions in a short time' by 31.4%. The very low level of agreement in this case may have been due to poor wording of alternative definitions.

"The patients did not reach complete agreement of definition for any term. By comparison with the 'majority doctors' definition,' between 80 and 90% of patients answered 'a good appetite,' 'arthritis,' 'heartburn,' and 'bronchitis' correctly. About three-quarters correctly defined

'jaundice,' 'least starchy food,' and 'piles,' while only 50 to 60% agreed with the majority of doctors for 'constipation' and 'palpitation.' The lowest responses for correct definition of terms were for 'a medicine' (43.2%), 'flatulence' (42.9%), and 'diarrhea' (37.0%). Patients displayed a considerable lack of knowledge of simple anatomy, the best understood terms being 'intestines' (76.9%) and 'thyroid gland' (69.9%), and the poorest 'heart' (42.1%) and 'stomach' (20.2%)."

This study in semantics was aimed mainly at the future use of the computer in diagnosis. It is mandatory that we have a vocabulary of medical terminology that is less ambiguous or more limited and practical. Education must also be considered as there is a definite relationship between vocabulary performance and scholastic attainment of the patient. We must also recognize the fact that there are large areas of misunderstanding between conventional medical opinion and the erratic notions of the lay mind.

T. R. Van Dellen, M.D.

Reference

1. Charles Murray Boyle: "Difference between Patient's and Doctors' Interpretation of Some Common Medical Terms," *British Medical Journal* (May 2) 1970, pages 286-289.

Slaughter on the Highways

Fund-raising organizations across the nation cheer wildly when they achieve their goal or set a new record. We have set a new record on America's highways . . . not the kind to cheer about—but the kind that should call for a great public reaction.

More than 56,500 persons were killed in highway accidents in 1969—the highest number in history. And, more than 4,700,000 men, women and children were injured last year. That's a lot of pain and suffering—but it doesn't seem to stop the slaughter.

We react with apathy.

56,500 killed, 4,700,000 injured. These numbers may be over your head. If they don't hit where you live—and drive—you might try to recall whether an acquaintance, a friend or a relative was in a traffic accident in '69. He didn't get a scratch? He was lucky. Nearly 5 million men, women and children were not that lucky.

In The Travelers Insurance Co.'s annual

booklet of highway accident data, a comparison of specific types of accidents in 1969, with those during 1968, reveals a 15% increase in single-car accidents. Once again the accelerator was the big gun. Whether it was a muscle car with the enticing name of a beast of prey or a ten-year-old clunker, there was a human foot on every pedal.

It seems clear that drivers continue to be the ultimate culprits. X.



40-hour-week: myth for Medical Assistants

BY RUBY JACKSON/CHICAGO

The 40-hour-week is a myth as far as Medical Assistants are concerned. They, like their employers, are willing to spend many more hours in self-improvement and service to the public.

Since our goals include efficient service to both the profession and the public, self-improvement has a major share in our lives. The Illinois Medical Assistants Association contributes to this educational process by providing seminars throughout the year designed to broaden our knowledge not only in the field of medicine but in medico-legal aspects, public relations as well as office management.

The Medical Assistant has an opportunity to exchange ideas and experiences with

others working in her field and thereby enlarges her knowledge which is reflected in her work. She will receive publications designed to increase her capability in your office and practice. So the 40-hour-week for Medical Assistants is many years away. She prefers to continue her education through on-the-job training, educational lectures and idea exchanges with other Medical Assistants, which results in a sense of personal accomplishment as well as better performance and management in your office.

For more information please write Mrs. Norma Domanic, 150 Ash Street, New Lenox, Illinois 60451 or Mrs. Vivian Kraft, RR #2 Normal, Illinois 61761.

The Next Industrial Revolution

In the next industrial revolution, there must be a loop back from the user to the factory, which industry must close. If American industrial genius can mass-assemble and mass-distribute, why cannot the same genius mass-collect, mass-disassemble, and massively reuse the materials? If American industry should take upon itself the task of closing this loop, then its original design of the articles would include features facilitating their return and remaking. If, on the other hand, we continue to have the private sector make things and the public sector dispose of them, designs for reuse will not easily come about. (Athelstan Spilhaus, "The Next Industrial Revolution," *Science* 167:3926 [Mar. 27] 1970, page 1673.)

SOCIO ECONOMIC *news*

A service of the Public Relations and Economics Division

By JOSEPH J. LOTHARIUS

An Inconsistency In Medicare Law?

A Medicare regulation program calls for patients in extended care facilities (ECF) to be seen at least once every 30 days by their physicians. This is required if the ICF wishes to retain its Medicare eligibility status. However, strictly speaking, if the physician reports his monthly visit on the ECF patient as not being "medically necessary," he will not be re-imbursed by the Medicare carrier.

According to Medicare regulations for re-imburement, no automatic or administrative visits are allowed. So, to get paid, the MD might be required to "*falsely claim his visit is medically necessary.*" There seems to be some incongruity in the Medicare law on this point. The regional office of the Bureau of Health Insurance has asked the Social Security Administration office in Baltimore to make an official judgment on this question.

County Societies Establish Peer Review

More than one third of the state's 92 county medical societies have established peer review committees and reported the names of committee members to ISMS. Thus far, 39 county societies have responded on an ISMS questionnaire requesting this information. (Thirty-seven of these have appointed a committee.) Of the state's 11 trustee districts, the Ninth District, comprised of 14 counties, leads with eight responses. District Seven, comprised of 11 counties, is next with six replies; the Eighth District, 11 counties, is third with five replies, followed by the fourth District, 12 counties, with four responses.

ISMS Trustees have been asked to contact those counties in each of their districts which have not yet established peer review mechanisms or requested that such peer review be done by the District Peer Review committee.

Speed-Up Promised For Medicaid Bills

A speed-up in processing previously rejected Medicaid bills has been promised in the near future by the Illinois Department of Public Aid (IDPA). Department officials said all bills, rejected for any reason whatsoever, would be returned to the individual physician immediately. Formerly, rejected bills had been held for a time to determine eligibility and the appropriate county department notified in an attempt to correct the bill and process it for payment. This resulted in delays. The new system will expedite bill processing and will promptly inform the physi-

cian of the reasons why his bill was rejected. In the long run, IDPA officials think the new method will also speed up bill payment.

IDPA Agreement Form Cancelled

ISMS members soon will no longer be required to sign a separate IDPA agreement form when treating public aid patients. According to IDPA, the Department of Health Education and Welfare (HEW) has given its approval to a revised version of the agreement which will be included on every IDPA billing form and signed by the physician. IDPA officials said the new billing forms should be in use sometime this fall.

TAM . . . a new mannequin for museum



TAM, a new transparent anatomical mannequin designed specifically for educational museum display can be seen and heard in the center of the Medical Balcony of Chicago's Museum of Science and Industry.

A grant to the Museum, presented jointly by the Illinois State Medical Society, the Chicago Medical Society and the American Medical Association, made the exhibit possible.

Created by Richard Rush Studio of Chicago, TAM is a full-sized, three-dimensional model showing the normal anatomy and describing the bodily functions of the human female. Unlike her predecessors in the medical education field, TAM is cast of crystal clear epoxy with a translucent outer "skin," and interior surfaces hand-painted in translucent color.

All of her organs are visible, her bones and muscles and nerves apparent, but obscuring nothing of medical importance. The central interior lighted section has been constructed so that each organ is made visible when illuminated during the progressive accompanying narration, even though it may be behind a layer of muscle or some other element.

The three scripts have been written in an informal and contemporary manner, directed to physicians as well as children. The scripts are electrically impulsed to actuate the lighting system which illuminates the various organs of TAM's body as the narration explains them.

TAM replaces the recently retired Camp Transparent Woman, long one of the Museum's most popular attractions. The mannequin can be seen by the public during the Museum's regular visiting hours.

Let's Improve Quality of Spirit

"Our purpose to improve the quality of man's life must encompass more than the physical, outward and tangible aspects of life. The intangibles of spirit and attitude are necessary both to give meaning and satisfaction to life and to provide the drive and motive power for finding the answers to the flaws that we must admit exist and give rise to our problems."—F. Ritter Shumway, new president, Chamber of Commerce of the United States.



public
affairs
library

reviews

MEN, MONEY, AND MEDICINE. By Eli Ginzberg, Columbia University Press, New York, \$8.50.

This book presents an in-depth commentary on the changing structure of health services in the United States with major emphasis on the rapid changes that followed the introduction of Medicare in 1965. It clearly conveys the ways in which American Medicine is rooted in the large fabric of our national life and indicates the changes that must be made in our values and institutions before the health industry can be significantly restructured.

Four sections make up this systematic appraisal of the political economy of health. In Part One, two themes predominate: What are reasonable expectations of a system of medical care for an affluent country which still is confronted by many unmet needs? And what have been some of the important financial and manpower transformations of the system as the nation has attempted to improve both the provision and distribution of health services?

In Part Two, the focus is on the critical role of the physician, who stands at the apex of the system and whose cooperation

is required to accomplish significant changes. Particular attention is directed to the fact that physicians, as all Americans, are free to determine where and how they work, and to the implication of this freedom of choice for inducing changes in the on-going system of medical care.

Part Three is concerned with the ever larger role played by allied health manpower. Particular note is taken of the potentialities and limitations of the leadership of specific occupational groups in rationalizing their training systems and altering employment practices so that their members can work more effectively and receive higher compensation.

Part Four is concerned with illuminating the problems of persons suffering from chronic conditions or mental disability, and the extent to which their medical needs are intertwined with the socioeconomic structures in which they live and work.

In conclusion, the authors point up the lessons that can be extracted from the last twenty-five years of the nation's efforts to improve its system of medical care and relate these lessons to the challenge that lies ahead.

Legislatively speaking.....

BY THE ISMS LEGISLATION
& PUBLIC AFFAIRS DIVISION

Senate Bill 1425, backed by ISMS, which exempts medical student loans from the state's usury law, was signed by the Governor on June 29, 1970.

The bill, which was sponsored by Senators Groen (R-Pekin) and Dixon (D-Belle-ville), will hopefully be of some aid to the doctor shortage in Illinois.

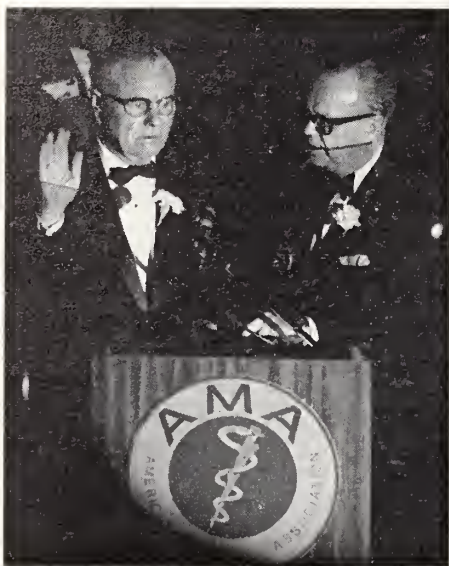
Senate Bill 1425 will now exempt loans to medical students above the state's usury law of 8%. Continental Illinois Bank and

Trust Company provides about 75% of the loans now being made to medical students. The AMA has eliminated the risk factor by guaranteeing repayment of all defaulted loans.

Loans may now be made with the interest rates to exceed the state's usury law, a 1% payback over "prime" during the training period and 2% over "prime" during the repayment period.

An amendment was attached in the House to eliminate this exemption in January, 1972.

Progressivism at the AMA



A presidential oath

Walter C. Bornemeier, M.D., Chicago, was sworn in as 125th president of the AMA on Wednesday at the Presidential Inauguration Ceremony by Burtis E. Montgomery, M.D., chairman of the Board of Trustees.

Walter C. Bornemeier, M.D., 125th president of the AMA, in his inaugural address touched upon the following points:

- alteration of approaches in training physicians to bring about an early solution to the shortage of physicians
- a five-point program to improve patient care
- shortening of the medical curriculum
- modernizing and shortening residency programs
- involving students in patient care earlier in their studies
- assimilating many full-time medical teachers into patient care and reducing the number of researchers and research institutions

AMA liberalizes abortion stand. .

Abandoned was the AMA's traditional opposition to abortion except for specific medical reasons. A new policy calling abortion a "medical procedure" to be performed by a licensed physician in an accredited hospital following consultation with two other physicians chosen for their "professional competence" was adopted.

"Determinative" factors in considering abortion should be "sound clinical judgment . . . together with informed patient consent," according to the new policy.

\$40 dues increase set for 1971 . .

A \$40 dues increase was approved by the House of Delegates, raising the dues to \$110 annually, effective Jan. 1, 1971. The AMA bylaws were also changed to authorize the fixing of annual dues by the House rather than the Board of Trustees.

Liability program approved . . .

A professional liability insurance program for members of the AMA was approved by the House of Delegates. The program is intended to provide long-term

protection to members of the AMA in those states in which the state medical associations elect to accept the provisions of the programs and agree to become joint sponsors.

AMA planning committee established . . .

The House of Delegates established a Committee on Long Range Planning and Development and took action on 20 other recommendations contained within the Himler Report, calling for some controversial changes in health care delivery, ranging from a definition of health—"Health is a state of physical and mental well-being"—to a more controversial recommendation calling for the AMA to sponsor and promote the formation of, and participate in, a National Academy of the Health Pro-

fessions for Research and Policy.

House acts on special committee's recommendations . .

In other action, the House adopted the recommendation of its special reference committee which heard the views of representatives of consumer and other groups.

It was agreed that the AMA's Board of Trustees should consider creating a multi-ethnic advisory committee on health care problems of minority groups; also that the House should consider establishing a reference committee at each Annual and Clinical Convention to hear the views of consumer and other public groups concerned with health care.

The House reaffirmed its positions that it is the basic right of every citizen to have available to him adequate health care.

Sheen Award recipient

Charles B. Huggins, M.D., Nobel Laureate and University of Chicago Pritzker School of Medicine physician-researcher, was the recipient of the \$10,000 Sheen Award for outstanding contributions to medicine. Howard F. Haneman, (left) senior vice-president of the Guarantee Bank and Trust Co. of Atlantic City, N.J. presented the check and Walter C. Bornemeier, AMA president, gave Dr. Huggins a commemorative plaque.



House acts on Illinois resolutions . . .

The following action was taken by the AMA House of Delegates upon the resolutions submitted by Illinois:

72—Individual Public Relations

- adopted an amended resolution urging each member of the House of Delegates to personally present to the local news media the story of progressive medicine and accurate figures contrasting costs of various types of insurance programs, hospital costs in private and government hospitals, and the results of utilization, peer review and other such committees in light of the critical news coverage which implies that only a government sponsored national insurance program can solve the nation's health problems.

66—Protection of the Public from Unwarranted Medical Statements

- adopted an amended resolution calling for the AMA House of Delegates to reaffirm the right of individuals to seek redress for injuries incurred from unwarranted medical statements and that the AMA through its public relations program inform the public of this policy.

67—Residency Training Programs

- rejected a resolution requesting the House of Delegates of the AMA to condemn the actions of specialty boards which have lengthened their training requirements, thereby discouraging more physicians from entering already critical specialties such as pediatrics and anesthesiology,



Presidents all!

Three of Illinois medical presidents gathered together in the post-inauguration reception line. (Left) J. Ernest Breed, M.D., president of the ISMS, Walter C. Bornemeier, M.D., president of the AMA, and Fred A. Tworoger, M.D., CMS president.

upon receiving information that requirements have not been increased from representatives of the specialties in question.

68—*Liaison with Hospital Boards*

- adopted a substitute resolution calling for the creation of an effective liaison between physicians on hospital staffs and the individual members of hospital boards of directors by encouraging hospital medical staffs to purchase individual subscriptions to the *American Medical News* or other appropriate publications for members of the hospital board of directors.

88—*Hospital Reimbursement*

- referred to the Board of Trustees for disposition a resolution requesting the AMA House of Delegates to endorse the procedure calling for prospective rate negotiation as the method of hospital reimbursement and urge the Blue Cross plans and government agencies to adopt this method as the basis for hospital negotiation and the determination of hospital reimbursement.

69—*Pagination Policy of the JAMA*

- referred to the Board of Trustees a resolution that JAMA discontinue its current policy of pagination, whereby adver-

tising pages are placed in the scientific text section, and return to the former practice of numbering editorial and scientific pages independently of the advertising pages, for binding purposes.

70—*AMA/AMPAC Workshop-Washington D.C.*

- referred to the Board of Trustees a resolution proposing that the Division of Public Affairs sponsor an annual public affairs conference in Washington D.C., with a program designed to attract a large number of medical society members from each state and scheduled for a midweek time when the maximum contact can take place between physicians and their elected representatives.

71—*AMA Physician's Public Affairs Council*

- rejected a resolution calling for the establishment of a Public Affairs Council or Committee to assist in planning and programming the public affairs program which is implemented by the Division of Public Affairs.

65—*Promotion of the Private Practice of Medicine*

- adopted a resolution that the AMA expand its efforts toward continuing the promotion of private practice of medicine.

A Younger Population

If you sense that there seems to be more young people around today, you're right. In the past decade, the population 14 to 24 years old increased almost 12 million, to 39 million, and the proportion of total U.S. population rose from 15 per cent to 19 per cent.

Film Reviews

"SAF-T-COIL-Insertion Techniques and Effectiveness," is the title of a film which presents a detailed demonstration of an improved insertion technique which appears to have contributed to the unsurpassed success rates achieved with this intrauterine device.

The data presented in the film, summarize three recent studies of a combined total of 3,640 patients in which pregnancy prevention rates were as high as 99.7%, with removals for serious complications or infection amounting to only 0.2% in one study.

The 8mm, color and sound film is available on free loan to physicians, family planning groups, and others involved in family planning. Contact: Julius Schmid, Inc., 423 West 55th Street, New York, N.Y. 10019.

* * *

"Human Blood Cell Morphology" depicts normal cellular elements and morphological alterations in red cells, white cells and platelets. A descriptive key emphasizes changes in size, shape and color of red blood cells in acquired and congenital anemias; and white cell changes which occur in infectious, metabolic, and neoplastic diseases.

The 108 frame, 35mm color photomicrographic transparencies would be of interest to personnel concerned with clinical hematology laboratory procedures.

Contact for free short-term loan: National Medical Audiovisual Center (Annex), Station K, Atlanta, Georgia 30324.

* * *

"Controversial Aspects of Rheumatoid Arthritis" covers the diagnostic criteria of rheumatoid arthritis, its differentiation from other syndromes, the various therapeutic regimens advocated, and the prognostic factors affecting such patients. Contact for free short-term loan: National Medical Audiovisual Center (Annex), Station K, Atlanta, Georgia 30324.

* * *

"Oral Cancer: Detection and Diagnosis" is geared toward increasing the ability of dentists, physicians and dental hygienists to detect and diagnose oral cancer in its earliest stages. Available on free short-term loan by contacting: National Medical Audiovisual Center (Annex), Station K, Atlanta, Georgia 30324.

"Bladder Outlet Obstruction in Children—Diagnosis and Management" is a 16mm, color, sound film which discusses types of bladder outlet obstruction, symptoms and diagnostic techniques. Non-surgical anti-reflux treatment and surgical techniques for bladder neck revision and ureteral reimplantation are demonstrated in the film.

Contact: National Medical Audiovisual Center (Annex), Station K, Atlanta, Georgia 30324.

* * *

"Popliteal Artery Entrapment Syndrome" is a 16mm, color, sound film which shows symptoms and surgical treatment of three cases of popliteal artery entrapment syndrome resulting from congenital anomaly.

Contact: National Medical Audiovisual Center (Annex), Station K, Atlanta, Georgia 30324.

* * *

"Control of Blood Loss in Extensive Autografting" demonstrates the hemostatic technique used successfully by the U.S. Army Research Unit to control blood loss in extensive autografting.

The 16mm, color, sound film can be secured on free short-term loan by contacting: National Medical Audiovisual Center (Annex), Station K, Atlanta, Georgia 30324.

* * *

"Tricuspid Valve Replacement Following Blunt Trauma" demonstrates surgical replacement of tricuspid valve, and focuses on the diagnostic evaluation of the trauma and surgical insertion of the prosthetic valve.

Family Practice exam slated

The American Board of Family Practice announces that it will give its second examination for certification in various centers throughout the United States. The examination will be over a two-day period on February 27-28, 1971.

Information regarding the examination and eligibility can be obtained by writing: Nicholas J. Pisacano, M.D., secretary-treasurer, American Board of Family Practice, Inc., University of Kentucky Medical Center, Annex #2, Room 229, Lexington, Kentucky 40506.

The deadline for receiving completed applications is November 1, 1970.



CMS calls for cooperativ

Educating

Dr. A. Nichols Taylor, president of Chicago Medical School/University of Health Sciences joined the institution in 1967. He was formerly director of the AMA's department of allied medical professions and services, and associate secretary of the Council on Medical Education.

BY JUNE BLYTHE/CHICAGO

Over the past 12 years the cost of health care has risen over 57%, almost twice the increase of other cost-of-living factors. The American Medical Association estimates that the nation is short 50,000 doctors. The Illinois State Medical Society says there are only six doctors in practice for every ten needed in the state. In six out of seven health professions, including nurses, medical and dental technicians, pharmacists, and dieticians, Illinois cities fall well below the national urban average in ratio of professionals to population.

Shortages and high costs restrict the accessibility of health care for much of the populace, but inner-city neighborhoods bear the most tragic impact. Such areas have only half as many physicians in private practice (0.62 per 1,000 population) as more affluent areas (1.26 per 1,000), according to a study for the Chicago Board of Health by Drs. Mark H. Lepper and Joyce C. Lashoff. Neighborhoods such as Lawn-dale and Englewood suffer an infant death rate from such treatable illnesses as influenza and pneumonia that runs four to five times the rate in areas such as Chicago Lawn and Rogers Park.

Crisis in Health Care

"There is a crisis in American health care," asserted the National Advisory Commission on Health Man-power in a report to the President. It went on to issue this warning: "Unless action is taken soon, health problems—like the problems of our neglected urban centers—may no longer be controlled."

The Commission has called for "a creative partnership of public and private enterprises" which

"might even become a useful model for progress in other fields."

Hope for just such a model lies in the innovative plan of the Chicago Medical School. Since its founding in 1912, the school has been solely committed to training physicians, but recognizing that physicians alone can no longer serve the health care needs of the public, the CMS board of trustees announced in 1967, the formation of a University of Health Sciences. It is the first school in the nation to develop an educational program around the total health team concept.

In addition to maintaining the title and identity of the Chicago Medical School, the University of Health Sciences encompasses a developing School of Related Health Sciences, and a School of Graduate and Post Doctoral Studies, already underway.

Remove Obstacles

The goal of the university is to remove the dead-end obstacles to advancement that plague most of today's three million health workers, while simultaneously doubling the school's production of physicians.

Says Dr. LeRoy P. Levitt, dean of the Chicago Medical School:

"There will be new educational, employment, and professional opportunities for inner city residents, who in turn will enhance the quality and quantity of health care available in their communities."

Construction Grant

Steps to forge the public-private partnership already are underway. CMS recently became the first

ffort

he total health team

private medical institution in the country to receive a direct state construction grant, when Governor Richard Ogilvie signed a bill awarding \$6.1 million toward a new classroom building adjoining the present structure at 2020 West Ogden Avenue. CMS soon will apply for an \$8 million Federal grant and anticipates that the enlarged facilities will double its class of medical graduates from some 80 to 160 annually within six years after the funds become available. Illinois applicants will have preference for the additional openings provided by the expansion. CMS will continue its 55-year commitment to train substantial numbers of general practitioners as well as specialists.

Private industry, foundations, and alumni are being asked to step up their contributions to support

both the expanded physician training and the new School of Related Health Sciences. Herman M. Finch, Chicago industrial relations counsellor and chairman of the school's board of trustees, points out, "The support of the medical professions is the most important function of the citizenry. Without a healthy nation, there is no use talking about economic or intellectual developments."

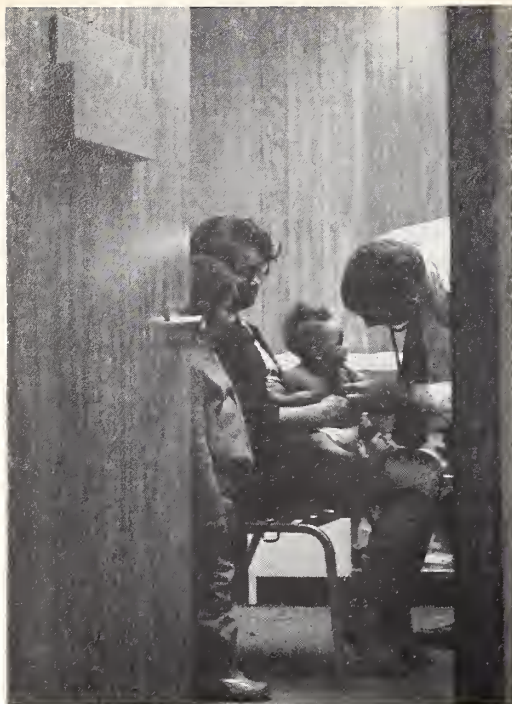
The trustees have already been raising a minimum of \$6,000 per year for each medical student, whose tuition pays only about one-fourth of the \$8,000 annual cost of educating him.

Bargain Program

But in dollars as well as time, the program is a bargain. Today's cost of building a new medical



CMS faculty provides staff for the Martin Luther King Neighborhood Health Center and its medical students train there. Funded by the Office of Economic Opportunity, the Center gives training in paramedical work to members of the community.



"Unless we improve the system through which health care is provided," says the National Advisory Commission on Health Manpower, "care will continue to become less satisfactory, even though there are massive increases in cost and in numbers of health personnel."

school is in the range of \$80 million to \$100 million, in addition to the time required to recruit a faculty and the lag before graduates can actually enter practice.

Dr. A. Nichols Taylor, CMS president, points out that if each of the nation's 90 existing schools would add only ten students, it would be the equivalent of opening nine new medical schools, based on the average size of entering classes. Fitting deeds to conviction, CMS last year admitted 12 per cent more medical students. Nationally, there are more than two qualified applicants for each of the approximately 8,800 places in each year's entering classes of medical schools.

The health care crisis, however, goes beyond numerical shortages. "Unless we improve the system through which health care is provided," says the National Advisory Commission, "care will continue to become less satisfactory, even though there are massive increases in cost and in numbers of health personnel."

Americans Jolted

Yet Americans have been rudely jolted to learn that 20 other countries now exceed the United States in life expectancy for males and that 18 have lower infant death rates.

Paradoxically, a major factor complicating the "delivery" of health care is the advancement of knowledge and techniques. Some 250 new procedures or modifications of old ones, and 30 new pieces of equipment enter medical technology each year, according to a report prepared for the Illinois Board of Higher Education under the direction of Dr. James A. Campbell. Today's physician must have a small

army of paramedical personnel just to take advantage of this proliferation of techniques.

Meanwhile, the proportion of doctors providing direct care to patients has declined, from 98.5 per cent in 1930 to 64.9 per cent in 1966. Almost one doctor in ten no longer treats patients, but performs the equally essential tasks of teaching, research, preventive medicine, etc. And of those who do treat patients, about one-fourth now perform this service through hospitals or other institutions. Especially scarce are general practitioners, the family doctors, with less than 2 per cent of today's graduates entering general practice.

At the same time, hospital care, too, must accommodate the multiplying technology. Over a 15-year period, says the Campbell report, the number of laboratory and diagnostic procedures (such as X-ray) for each hospital admission have more than doubled—one important cause of mounting costs and personnel shortages.

Just as numbers alone do not explain the medical supply shortage, neither does sheer population growth clarify the swelling demand. Dr. Taylor points out that the population profile is changing, with the biggest growth coming in the proportions of the young and the old—the two ends of the spectrum requiring the most medical care. Further, the effective demand has been boosted by third-party payments, via private and public insurance and aid programs—more people can afford more care. Finally, the amount of public information about health care has risen to the point where medical service no longer is regarded as a privilege, but as a right.

(Continued on page 175)

Total health team

(Continued from page 172)

One Basic Solution

One basic solution, says Dr. Taylor, is to increase the individual physician's effectiveness. If, for example, he has been seeing two patients an hour, he could be helped with the right kind of supportive personnel to see three patients an hour. In effect, the number of physicians would rise by 50 per cent.

Cooperative Effort

CMS plans call for a cooperative effort with six hospitals, four community colleges and two vocational schools to construct a correlated educational and job training program through which the individual can progress, with his pace dependent only on his ability and potential. A ward aide, for example, could proceed through training and jobs as a licensed practical nurse, to a degree nurse, and then a baccalaureate degree at CMS without at any step having to repeat mundane essentials learned at an earlier level. The professional nurse could then, if desired, apply for medical school, or for graduate work in one of the medical sciences.

Heading up the program as dean of the School of Related Health Sciences is Dr. Israel Light, who left his career post at the National Institutes of Health to take on this new challenge. Dr. Light was chief of educational program development for the allied health field in the Institute's Bureau of Health Manpower.

Next fall the School likely will offer a two-year degree course in physical therapy (with a two-year general college background as a prerequisite.) This may be followed by similar courses in occupational therapy and radiologic technology. Courses in physical and occupational therapy are offered at only two other colleges in the state, and no bachelor's

degree in radiologic technology is available despite the acute need for managerial and supervisory personnel in this field.

Discussions also are underway for CMS to assume teaching responsibility for paramedical courses now offered at Mt. Sinai Hospital, the teaching hospital for CMS medical students.

Dr. Light shares with Dr. Taylor a sense of commitment to the needs of the communities surrounding CMS and the West Side Medical Center where it is located.

"We live in a certificate-oriented society," comments Dr. Light, "and we have confused 'education' with 'competence.' We want to try to bridge the gap between academia and the world of work, to salvage people of ability who have never had the opportunity to get that certificate."

Enthusiastically Endorsed

This thesis is endorsed enthusiastically by Dr. Kermit Mehlinger, director of the Martin Luther King, Jr., Neighborhood Health Center, at 3312 West Grenshaw. CMS faculty provides staff for the Center, and its medical students serve there as part of their training. Funded by the Office of Economic Opportunity, the Center also gives training and employment in paramedical occupations to members of the community. Land and the building were provided by Sears, Roebuck and Company.

An even closer and more formal relationship between the Center and CMS, with expanded training opportunities from the high school level upward, is expected soon.

A similar relationship is anticipated when Chicago constructs a city neighborhood health center in the area. This would be one of the three centers for which bonds were voted in 1966, now slated to be built under the Model Cities program.

(Reprinted from *Commerce*, February, 1970)

Neighborhood Health Center

The health-center movement developed in many places throughout the world. Centers became a part of governmental systems of health care in such countries as Russia, Yugoslavia and Chile. The English plans were never realized although a flurry of centers was reported after World War II and the famous Peckham experiment.

The new centers are now being sponsored by hospitals, medical schools, citizen groups, medical societies and, less often, by health departments. Under new sponsorship, these centers are developing at the same time that group practice, a kind of private entrepreneurial health center, receives a stamp of professional and public approval and when another health-center movement in mental health, quite separated from medical practice, has also developed. (John D. Stoeckle, M.D., and Lucy M. Candib: "The Neighborhood Health Center—Reform Ideas of Yesterday and Today," *New Eng. J. Med.* 280:25 [June 19] 1969.)

Iodized Salt for the Prophylaxis of Endemic Goiter

It is necessary again to review the problem of goiter prophylaxis. There is ample data proving that endemic goiter can be prevented, and simple practical methods of prevention are known. The present need is to place this important public health problem under the proper authority so that it will be continued generation after generation.

The prevention of endemic goiter in man on a large scale was begun in 1916. This research was started through the public schools in Akron, Ohio, by Marine and Kimball and was described in detail at that time. By 1920, it had been shown most convincingly that endemic goiter in adolescent girls could be prevented by keeping the thyroid saturated with iodine. From 1920 to 1924, many cities both in the United States and abroad were carrying out parallel programs for the prevention of goiter.

During these same years an improved method of determining minute quantities of iodine was developed, and by 1924, the water in our endemic goiter regions had been analyzed.

The Michigan State Department of Health and the Michigan State Medical Society made the first organized effort to prevent goiter by the use of iodized salt. The salt producers agreed to make a table salt containing potassium iodide 0.02%. The wholesale grocers agreed to handle, as far as possible, only iodized salt for table use. The cost of this iodine was borne equally by the producers and by the wholesale grocers, so that the cost to the consumer was the same as for ordinary table salt.

Neither the manufacturer nor the wholesale grocer was to advocate the use of iodized salt or to advertise it in any way. Promotion was left entirely to the state department of health and to the medical profession. Lectures, newspaper articles, radio talks and placards in every school explained briefly the thyroid gland, its function and chemistry. The dependence of normal thyroid function on iodine was stressed, and the deficiency of iodine as the sole cause of endemic goiter was repeatedly emphasized. This campaign resulted in the use of iodized salt in approximately 75% of the homes in Michigan beginning in May, 1924.

As was expected, there were a few papers written by medical men expressing anxiety and fear lest the use of iodized salt produce toxic goiters. Because of these few articles, which made some startling claims, it was necessary in 1927, and 1928 to make a resurvey throughout the same counties in Michigan, both to learn the efficiency of iodized salt and to determine any harmful effects from its continued use. Stated briefly, the use of iodized salt was a very efficient and practical method of goiter prophylaxis and found to be entirely safe. Throughout this resurvey not a child was found who showed the slightest ill effect from the use of iodized salt.

In spite of the many surveys in this country and abroad, there appears to be no cumulative knowledge among the general population about the cause and prevention of endemic goiter. Furthermore, there is an abundance of data on the efficiency and safety of iodized salt as the means of prophylaxis; yet the consumption by the general public gradually decreases unless repeated campaigns are made by state health departments to encourage its use. (O. P. Kimball, M.D.: Iodized Salt for the Prophylaxis of Endemic Goiter. *J.A.M.A.* [Jan.] 1946. 130:80-81.)

Why the Coins Drop Slowly Away

"Inflation doesn't rob the cash register in a direct and honest way. It merely eats the bottom out of it and the coins slowly drop away."—Jenkin Lloyd Jones, president, Chamber of Commerce of the United States.

THE VIEW BOX

(Continued from page 129)

Diagnosis: Mediastinal pancreatic pseudocyst

The occurrence of a mass which extends in continuity from the retroperitoneal to the posterior mediastinal space with an anterior displacement of the esophagus and stomach should suggest the entity of mediastinal pseudocyst. This is a rather rare condition with seven cases reported in the American literature.

An abdominal exploration disclosed a huge mass adherent to the posterior wall of the stomach which extended through the esophageal hiatus and displaced the esophagus anteriorly. The mass arose in the body of the pancreas and when probed yielded 500cc of fluid with serum amylase of 2048 units. A cystogastrostomy was performed. On the patient's return one year later, the pancreatic pseudocyst was recurrent without the mediastinal extension.

Reference

C. J. Reynes and Leon Love, "Mediastinal Pseudocyst," *Radiology* 92:115-116, January, 1969

Surgical Grand Rounds

(Continued from page 128)

which result from metastatic disease or other space-occupying lesions. I¹³¹ labelled Rose Bengal can be used to assess liver function by measurement of the rate of disappearance from the blood stream. In addition, it is excreted by the liver so that failure of the isotope to appear in the duodenum suggests obstruction of the bile ducts.

When available, these tests are useful and add considerable information, particularly when the cause of jaundice is obscure or uncertain. ◀

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September 14-18—Mallinckrodt Institute of Radiology

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September 28—Illinois Registry of Anatomic Pathology

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500 cases of appendicitis

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Become involved while the earth still has a chance:

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Don't leave the water running while shaving or brushing your teeth. Make sure your faucets don't leak; a few drops can add up to several hundred gallons a year. Use ice cubes if you want cold water; don't let the water run.
2. Burning rubbish and leaves only adds to air pollution.
3. Bury leaves, grass, organic garbage, etc. and use it as fertilizer for your garden. Organic garbage buried 6 inches deep will decompose and fertilize the soil.
4. Avoid buying beverages in no-deposit, no-return containers; these throw-aways neither burn nor waste away, and we're running out of places to bury them.
5. Recycle wastes: paper, aluminum, rags, etc.
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8. Avoid using internal combustion engines.
Use a hand mower instead of a power mower; a canoe or sailboat is healthier than a power boat.
9. Encourage natural predators like birds to control insects by planting trees and shrubs, and building bird houses.
Fertilizers with lead arsenate kill birds, pets and children.
10. Don't buy furs and other wild animal products. The demand for such luxuries hastens extinction of many species of mammals, reptiles and birds.

Pollution Control Spending Peaks

Pollution control spending rose 23% in 1969, to a record of \$256 million among 248 companies, according to a survey by the National Industrial Conference Board.

ON THE COVER

"Preserve" is the theme of this month's Illinois Medical Journal—ourselves and our environment. With the word "pollution" running rampant through everything we read, see and hear, it is time we each survey our own actions in terms of contributors to the pollution problem.

By voting "yes" on the November 3, anti-pollution bond issue, you can bring pollution control to the sewage problem now confronting Illinois waters. Taking the time out to cast your ballot is your way of initiating the mass clean-up that lies before us.

Cover art by Mike Ahearn.

BLUE SHIELD REPORT



FOR *Illinois Physicians*

Medical Assistant Workshops Underway

In September, Illinois Blue Shield will begin its annual dinner workshops for medical assistants in the counties of Cook, Kane, Will, Lake, DuPage, Winnebago and Lee.

As part of the ongoing Professional Relations program, for thirteen years Blue Shield has sponsored dinner meetings for medical assistants to help keep them abreast of changes in Blue Shield structures, procedures and methods, and to help them carry out their responsibilities more effectively for their physician employers.

The program following dinner will include a newly developed slide presentation showing our Blue Shield Plan offices and the steps that are taken to get a claim paid from the time it is mailed from the doctor's office to the time that a check is mailed to the doctor's office. The presentation will also include processing of Medicare claims, showing various departments at work. Following the slide presentation trained members of the Professional Relations Department will be available to answer questions relating to Blue Shield and Medicare.

Invitations to attend one of the dinner workshops will be mailed to all medical assistants in the seven county area and reservations should be returned promptly if they plan to attend.

Dinners are served at 6:30 P.M. and meetings adjourn at 9:00 P.M. The following dinner meetings have been scheduled:

Date	Place	Area
Sept. 24	Ramada Inn, Hinsdale	DuPage County
Sept. 30	Ramada Inn, Dolton	South Suburban
Oct. 7	Windermere Hotel	Southeast Chicago
Oct. 14	Henrici's, Rockford	Winnebago County
Oct. 15	Ramada Inn, Dixon	Lee County
Oct. 21	Oak Park Arms, Oak Park	Chicago
Oct. 22	Marriott Motor Inn	Northwest Chicago
Oct. 28	Lexington House	Southwest Chicago
Nov. 4	Arlington Park Towers	Northwest Suburban
Nov. 5	Green Tree Inn, Bensenville	West Central
Nov. 11	Hyatt House	Northwest Chicago
Nov. 18	Knickerbocker Hotel	Near North
Nov. 19	Knickerbocker Hotel	Near North

For additional information, please write or telephone Mrs. Loretta O'Donnell, Professional Relations Representative, Professional Relations Depart-

The Community— We Are Involved

In 1969 Blue Shield organized a new Community Affairs Department to make its resources available in the public service. Who needed us? Almost everyone, it seemed. Already, as a community service, we were concerned with our over-65 citizens, administering the medical-surgical portion (Part B) of Medicare in the metropolitan Chicago area. We have talked with our young people, too, alerting them and individuals of all ages to the dangers of drug abuse. To begin with, and through the generous cooperation of many TV stations throughout the state, we have shown three drug abuse documentaries, followed by live interviews with experts in this field. Next we distributed a booklet to more than 100,000 persons entitled "Adolescence for Adults", to help parents understand their youngsters a little better. To further help combat the drug abuse problem, Blue Shield is participating with law enforcement agencies, schools and churches by providing films and literature. Over 1,000 screenings of the documentaries were held and 1 million booklets were distributed in 1969. Blue Shield is also at work in the organization of voluntary blood collection programs to benefit all citizens. Blue Shield is involved in a number of community-based programs to encourage a higher level of health care among all socio-economic levels. Just as important, this kind of service is Blue Shield's primary aim in its newspaper, TV and radio advertising to the public.

The Model Cities program is another example of Blue Shield's concerned involvement in community needs. In December 1969, a contract was drawn with the City of Chicago to conduct a health-financing study in the four Model Cities Communities of Lawndale, Woodlawn, Grand Boulevard and Uptown. The study is one of 52 separate projects undertaken by the Department of Housing and Urban Development to improve living conditions for disadvantaged citizens. Blue Shield welcomes the opportunity to participate in community activities. We are involved.

ment, Blue Shield Plan of Illinois Medical Service, 222 North Dearborn Street, Chicago, Illinois 60601. Telephone (312) 661-2964.

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Those physicians who do not use the preprinted forms should indicate in item number 8 of the "Request for Payment" their full name and the address.

We often have to delay processing claims which could otherwise be avoided if complete information had been provided. A common reason for delay results from an itemized statement submitted by the Medicare beneficiary on letterhead listing more than one physician and when the physician who had provided the service is not identified. When this occurs, it is necessary for one of our Blue Shield representatives to contact you or your office assistant by telephone or letter to obtain the necessary information in order to make payment.

Delays resulting from such omissions can be avoided and payments speeded by providing us with the name of the physician who performed the service.

Payments To Group Practices

The Social Security Administration has developed procedures to be applied by the Part "B" Carrier when a group of physicians practicing together wishes to have Medicare payments made in the group's name rather than to individual physician members.

If all members of the group charge the same fees for similar services, they have in effect established a "usual fee" for the group which will be used as the basis of making Medicare payments.

When fees for similar services vary among the group members, an average (the median) of the combined charges will be used to determine the usual fee for the group.

If groups within the five county area of Cook, Kane, Lake, Will and DuPage wish to have Medicare payments made on this basis, contact the Professional Relations Department of Illinois Blue Shield, 222 North Dearborn Street, Chicago, Illinois 60601.

When You Accept Assignment

When a physician accepts a Medicare assignment for his charges, he may not bill the patient for charges disallowed for being higher than "usual and customary."

This is explained on the reverse side of the form 1490, "Request for Payment" which states, "If you and your doctor agree, Medicare will pay him directly. . . . Under this method the doctor agrees to accept the charge determination of the Medicare carrier as the full charge. . ." It is also explained in **Medicare, A Reference Guide to Physicians**, published by the Department of Health, Education, and Welfare, Social Security Administration, page 22.

The physician may, however, bill the patient for any unmet portion of the annual \$50.00 deductible, 20% (co-insurance) of the "reasonable charge", and any charge **disallowed** as **non-covered services** under Part B Medicare.

When the physician and his patient agree to an assignment, the patient **must** sign the "Request for Payment" form unless the patient is deceased or is a Public Aid Recipient. The physician **must** also sign the form and check the box marked "I accept assignment."

Notice of Change in Certification

The Social Security Administration no longer considers the following laboratories certified for Medicare participation:

West Lawn Medical Laboratory
4255 West 63rd Street
Chicago, Illinois 60629

Besley-Waukegan Clinic
215 North Sheridan Road
Waukegan, Illinois 60085

Our Government Contracts Division

reports that Federal Health Insurance benefits under Title XVIII, Part B of P.L. 89-97 were paid during July for over 55,000 cases in the counties of Cook, DuPage, Kane, Lake and Will for an amount exceeding \$3,700,000. For the year 1970 through July, payments have been made on over 386,000 cases for an amount exceeding \$23,000,000.

The number of cases processed in July under Part A exceeded 74,000 with payments to providers amounting to more than \$27,200,000. For the year 1970 through July over 479,000 cases have been processed and payments to providers have exceeded \$189,000,000.

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Meeting Memos

Sept. 17-19—Illinois State Society of Radiologic Technologists

35th Annual Meeting
Sheraton Hotel, Chicago

Sept. 18-19—American College of Physicians

Scientific meeting—Internal medicine
The Abbey, Fontana, Wisc.

Sept. 19-20—American Medical Association

3rd National Congress on Medical Ethics
Ambassador West Hotel, Chicago

Sept. 24—American Society for Testing and Materials

Organizational meeting of Committee on Forensic Sciences
ASTM Headquarters, Philadelphia

Sept. 24-27—American College of Physicians

Scientific meeting—internal medicine
Otsego Ski Club, Gaylord, Mich.

Sept. 26-30—American Fracture Association

Annual meeting
Americana Hotel, New York

Sept. 28—Illinois Registry of Anatomic Pathology

Special seminars
Hektoen Institute, Chicago

Sept. 30-Oct. 1—American Medical Association

30th Annual Congress on Occupational Health
Century Plaza Hotel, Los Angeles, Calif.

Sept. 30-Oct. 3—Association of American Physicians and Surgeons

Annual Meeting
John Marshall Hotel, Richmond, Va.

Oct. 2—The Cleveland Clinic Educational Foundation

Postgraduate course—medical technology
2020 E. 93rd St., Cleveland, Ohio

Oct. 5-9—American Academy of Ophthalmology and Otolaryngology

Annual Meeting
Dunes Hotel, Las Vegas, Nev.

Oct. 7—Forest Hospital

Demonstration course on "The Group Psychotherapies"
Forest Hospital, Des Plaines, Ill.

Oct. 9—Chicago Surgical Society

17th Annual Dinner
Cathedral Hall, University Club of Chicago

Oct. 12-16—American College of Surgeons

56th Annual Clinical Congress
Chicago

Oct. 18-23—American College of Emergency Physicians

2nd Scientific Assembly
Las Vegas, Nev.

Feb. 27-28, 1971—American Board of Family Practice

Second examination for certification
University of Kentucky Medical Center, Lexington, Ky.

Six Moon Steps for Communities

Businessmen and organizations concerned with attacking community problems effectively can learn something from the six steps our government took in approaching the problem of how to land a man on the moon.

These are the steps pointed out by Arch N. Booth, executive vice president of the Chamber of Commerce of the United States:

1. Make an exhaustive study of every aspect of the problem.
2. Agree on what is available to meet the needs outlined; what can be done, and by whom.
3. Decide in advance not to be intimidated by the magnitude of the task, its expense, or the time and effort required to perform it.
4. Set up an adequate organization of competent people.
5. Resolve to refuse to be stampeded into shortcuts or unrealistic time schedules.
6. Build into the program the capacity to rebound from failure, and to analyze and learn from mistakes.



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INDICATIONS: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, rhinitis, conjunctivitis, and otitis. **CONTRAINDICATIONS:** Hypersensitivity to antihistamines. Not recommended for use during pregnancy.

PRECAUTIONS: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. **SIDE EFFECTS:** Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered. **DOSAGE:** 1 Extentab morning and evening. **SUPPLIED:** Bottles of 100 and 500.

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J. Ernest Breed

The President's Page

Practicing physicians are in short supply

Everyone talks of the shortage of doctors, and the medical society as well as many other groups are making frantic efforts to increase the number graduating from medical schools. Since we have about one doctor for every 750 people in the United States it appears there should be no shortage, but everyone knows there is a shortage of *practicing physicians*. It seems too many doctors take jobs with insurance companies, industrial concerns, or work as administrators of medical schools, hospitals, medical societies or other organizations. Many are doing research or teaching. Many older doctors have retired from active practice. None of these doctors are taking care of sick patients.

Late this spring the Illinois State Medical Society sent a questionnaire to a total of 5,000 Illinois medical school students, interns and residents. The questionnaire was designed to learn their plans for the future. They were asked if they plan to practice medicine and if so, where and how. They were asked about research, specialization, general practice and if they planned to practice solo or to join a group. We are expending great effort to encourage the medical schools to graduate more general practitioners and are encouraging young doctors to go to the smaller towns in Illinois. We were eager to learn if our efforts are going to be successful.

We were also stimulated to question our successors since a similar questionnaire sent to students from an eastern school disclosed that only 60% planned to practice medicine, while 40% were going into research, administration or teaching.

Of the 5,000 questionnaires we sent out, a total of 1,396 were returned. Five hundred and ninety-four were from students, 252 from interns and 550 from residents. The results will be the subject of a series of future articles in the *Journal*. A preview discloses about 95% of those returning the questionnaire plan to practice medicine and 67% of these join a group. Of great significance is the fact that 14% of the *students* plan to do family practice, but only 1.4% of *residents* hold this plan. One wonders what happens to them between their student days and their residencies.

In the past, about 60% of our own graduates stayed in Illinois and of those residents answering the survey, about the same number plan to stay in the state. One disturbing discovery is that 63% of those who plan to stay in Illinois plan to practice in Chicago. The populations of Cook County and downstate are about equal, still Chicagoland now has twice as many physicians as practice in the rest of the state. From the answers of the residents one would believe this proportion would continue.

Perhaps those who do not plan to practice medicine should be given special university training outside the medical schools making room for those who would eventually take care of sick people. Certainly we should do all we can to attract young physicians to areas where practicing physicians are in short supply.

J. Ernest Breed M.D.

Clinics for Crippled Children

Twenty-eight clinics for Illinois' physically handicapped children have been scheduled for October by the University of Illinois, Division of Services for Crippled Children. The Division will count twenty-one general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing service. There will be five special clinics for children with cardiac conditions and rheumatic fever, and two for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

October 6 Carrollton—Boyd Memorial Hospital
 October 7 Metropolis—Massac Memorial Hospital
 October 7 Hinsdale—Hinsdale Sanitarium
 October 7 Rock Island Cerebral Palsy—3808 Eighth Avenue
 October 8 Lake County Cardiac—Victory Memorial Hospital
 October 8 Rockford—St. Anthony Hospital
 October 8 Flora—Clay County Hospital
 October 8 Springfield General—St. John's Hospital
 October 8 Cairo—Public Health Department
 October 9 Chicago Heights Cardiac—St. James Hospital
 October 13 Rock Island Area General—Moline Public Hospital
 October 13 Peoria—St. Francis Children's Hospital
 October 13 East St. Louis—Christian Welfare Hospital
 October 13 Quincy—Blessing Hospital
 October 14 Champaign-Urbana—McKinley Hospital

October 15 Bloomington—St. Joseph's Hospital
 October 15 Elmhurst Cardiac—Memorial Hospital of DuPage County
 October 21 Chicago Heights General—St. James Hospital
 October 23 Chicago Heights Cardiac—St. James Hospital
 October 23 Evanston—St. Francis Hospital
 October 26 Peoria Cardiac—St. Francis Children's Hospital
 October 27 Peoria—St. Francis Children's Hospital
 October 27 East St. Louis—Christian Welfare Hospital
 October 27 Danville—Lake View Hospital
 October 28 Centralia—St. Mary's Hospital
 October 28 Aurora—Copley Memorial Hospital
 October 28 Springfield Pediatric Neurology—Diocesan Center
 October 28 Mt. Vernon—Good Samaritan Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

Rebels Are Muzzled First After Rebellion

"If we permit campus minorities to foist their own biases on the university and push it into conflict with the fundamental values of our society, institutional autonomy will soon be taken away by the public that supports and ultimately controls higher education. The first members of the academic community to be muzzled by outside forces, furthermore, would be those who now wish to politicize it."—Dr. Logan Wilson, president, American Council on Education.

**Some days she can't seem
to function...**



Abstracts Of Board Actions

Board of Trustees Meeting
July 18-19, 1970
Arlington Towers, Arlington Heights

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. It covers only major actions and is not intended as a detailed report. Full minutes of the meetings are available upon any member's request to the headquarters office of the ISMS.

Continuing Education

In conjunction with the program in continuing education being developed by Dr. George Miller, University of Illinois, the Board approved formation of the proposed committee on continuing education. This is to be developed with an initial group of eight persons, four from the University of Illinois and four from ISMS, on an ad hoc basis, to develop preliminary plans. In subsequent discussion the Board took action to recommend that a representative of each Illinois medical school be invited to the initial meeting scheduled for July 27. Appointed as the ISMS members of the committee were Drs. Breed, Cannady, Gibbs and Dean Bordeaux (Vice-chairman, ISMS Committee on Continuing Education).

Foundations for Medical Care

This relatively new concept in the provision of health services was felt to be a subject of great importance. The Board instructed the Committee on Health Care Financing (formerly the Committee on Usual and Customary Fees) to make a thorough study of the possibilities and ramifications of such foundations and report at the next Board meeting.

In action taken after an initial meeting of the Committee on Health Care Financing, the Board adopted the committee recommendation recognizing the concept of these foundations, in philosophy, as another means of health care delivery.

Peer Review

A booklet of guidelines for Peer Review Committees, incorporating minor changes from previously approved guidelines, was approved. The Board directed that all counties be apprised of procedures to be followed and that the booklet be made available to them. Each Trustee was urged to work with the counties in his district to set up Peer Review mechanisms and to ensure that all Peer Review cases are handled in the most expeditious manner.

ISMS/CMS Joint Convention Planning

Acting upon the report of the Executive Committee and a joint planning committee, preliminary plans for a combined ISMS/CMS meeting were approved. Subsequent to actions of the House of Delegates, meetings have been held to accomplish combination of the CMS Clinical Conference and the ISMS Annual Meeting. These meetings included representatives from ISMS and CMS, and initially accepted recommendations include:

The name of the meeting may be Annual Midwest Clinical Conference (jointly sponsored by ISMS and CMS, with cooperating participating specialty societies).

There would be joint management of the meeting, likely scheduled in March, beginning in 1972.

The House of Delegates and the Auxiliary will meet concurrently with the clinical sessions. Further plans will be announced.

Hospital Relations and Reimbursement

A bill recently defeated in the Illinois legislature, SB 1145, would have extended state control over hospital additions and expansions. The bill also dealt with hospital planning agencies and was a prime recommendation of the Advisory Committee on Medical Costs and Utilization of Services. The ISMS House of Delegates passed resolution 70M-50, which covers rate negotiation as a preferred method of hospital reimbursement from government and carriers. The Advisory Committee also recommended this and 70M-50 is related to SB 1145 since rate negotiation can be used to bring financial responsibility into hospital operation and give impetus to hospital planning.

The Board appointed a special ad hoc committee to study this matter. Appointed were Drs. Jirka (chairman), Lees and O'Donnell. They will involve such council and committee chairmen as necessary, to avoid duplication of effort.

Consumer Advisory Panel

Due to the recognized need for education of the public in matters of health, health care delivery and personal care, the Board authorized establishment of a consumer advisory panel. Members will be appointed to this upon recommendation of the Task Force on Physician Shortage and Services to Medically Deprived Areas. The Task Force will establish the framework within which the panel will operate.

Reduction of State Laboratory Services

A letter to the governor, regarding actions taken in reducing laboratory services for budgetary reasons was authorized. The letter was to request that in the future such measures that affect medical care in Illinois be discussed with ISMS before being announced.

Professional Licensing Policies

Dr. Albert Glass, director of the Department of Mental Health, met with the ISMS Council on Mental Health and Addiction to discuss concerns about manpower shortages in the Department. Dr. Glass was present to discuss these with the Board as part of Dr. Falk's Council report. The Council reported on licensing policies of the Department of Registration and Education and recommended that physicians who are certified by the American Board of Psychiatry and Neurology and are licensed in another state, be licensed in Illinois upon written request by the Director of the Department of Mental Health. It was further rec-

(Continued on page 274)

Arteriography:

Principles and techniques

By PAUL B. SAVORY, M.D./CHICAGO


The last decade of radiology has seen the introduction of what is commonly referred to as "Special Procedures." While in fact the whole discipline of radiology is really one of the application of special procedures, its enlargement by the addition of, amongst others, arteriography is the subject of this writing. The experience and the development of certain dictums, though subject to change, are presented in the hope that an interchange of ideas will further add to the usefulness as well as limitations of this procedure.

Forsmann was the first to introduce a catheter into the vascular system *in vivo* of the human in 1928. He performed this upon himself, which must have required considerable confidence, as well as foresight. Moniz, in 1928, performed carotid arteriographies of amazingly good quality. All of this only goes to demonstrate that the early pioneers in radiology were not only ambitious but well qualified in their work.

Arteriography in radiology obtained a great impetus as the result of several developments. Mention must be made of Sel-dinger in Sweden, who in 1953, introduced an acceptably safe and successfully repetitive technique of introducing catheters in-

to the vascular system by a closed method.¹

Contrast material development largely belongs to pharmacology. All types to date employ the use of the element iodine, in various states of chemical combination with other elements to produce a substance of sufficient solubility, low viscosity, and reduced toxicity to enable its use in the living being. Moniz injected strontium bromide and sodium iodide. Diodrast and urokon were used extensively but suffer from high toxicity in volumes used in living beings. Thorotrast provides good contrast, and while non-toxic, it is radioactive. It is not used routinely. With the introduction of the methyl salts of these



Paul B. Savory, M.D., maintains a private practice in radiology and is on the staffs of Presbyterian-St. Luke's Hospital and the University of Illinois in that capacity. He received his M.D. degree from McGill University and served his internship at the Royal Victoria Hospital in Montreal, Quebec, and his residency at Presbyterian-St. Luke's Hospital.

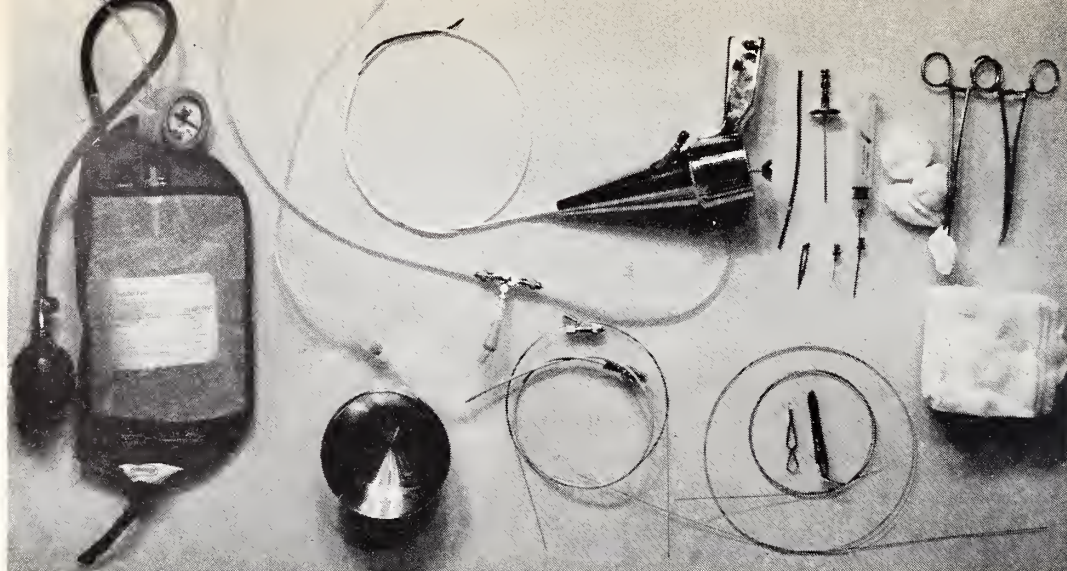


Fig. 1. The equipment usually employed for aortography and selective arteriography.

compounds, toxic reactions have been markedly reduced. Recently, the intravascular use of dextran has been shown to reduce, in particular, the cerebral reactions to iodinated compounds.²

Engineers and the manufacturers of X-ray equipment have played an important role in the field of arteriography. The event that is to be visualized in arteriography is for the most part rapid and is composed of more than one component. Thus, the need for a rapid production of consecutive films is the optimum. The producers of equipment have responded well through the years to the needs of the radiologist. Equipment is now available and reliable for the rapid serial filming, producing good detail and acceptable levels of safety.

Of more recent times, there has been a rash of activity in the development and improvement of kinds, types and sizes of the catheter materials. Further attention to this will be given later in this paper.

Patient Evaluation

The purpose of radiology is to supply as much information as possible about the patient, therefore the more the radiologist knows, the more he can tell. Evaluation of the patient prior to arteriography becomes paramount. The history, physical and all prior studies are reviewed carefully, not only to determine whether the study can be done but also in what manner; a decision which involves the least risk to the patient and the greatest degree of information to the physician.

Special attention is given to the patient's arterial system. It goes without saying that an artery that is not palpated cannot be

easily catheterized. Arteries are subject to diseases which may affect the procedure. Occlusive disease and atherosclerosis are of special concern to the radiologist. It has been our policy to avoid puncture of any artery, in which by history or physical there is either present or an impending possibility of precipitating arterial obstruction. Likewise, the patient's peripheral vessels are palpated and marked prior to any procedure; these marked vessels are used following the procedure to control the hemorrhage from the puncture site and to assist in evaluation of post procedure thrombosis.

A history of sensitivity to the contrast material is sought. In our experience, there has been a lower incidence of reactions when contrast is intra-arterially introduced as compared to intravenous injection. Speculation exists whether this decrease is the result of the material having to pass through tissues and thus, being dispersed before being delivered to the brain or whether the role of preoperative medication is responsible.

Very few patients are currently accepted for arteriography as an out-patient procedure. These examinations are usually restricted to a simple puncture for femoral arteriography and no pre-medication is given. Most studies are on in-patients and medication is given prior to the examination, consisting of Demerol 75 mg., Phenergan 25 mg., and Seconal 100 mg., unless otherwise indicated. Children and infants are well handled with Demerol 1 mg/kg, Thorazine 1 mg/kg, Nembutal 5 mg/kg, Atropine up to 15 lbs., .05 mg., 15-40 lbs. 1 mg., 40-75 lbs. 2 mg.

The examination is considered and treat-

ed as a consultation. A full report is put on the patient's record as well as a copy for the radiology department. The patient is visited following the procedure as well as the following day and any complications or adverse reactions are noted in the records.

Equipment

The personnel in the department are trained to maintain and set up the equipment trays and tables. In addition to the equipment required for the injection of contrast material, the set-up includes needles and syringes for the local anesthesia, syringes for flushing the catheter, etc. A typical set is shown in Figure 1.

The needles for femoral or axillary puncture are of two sizes, .035" and .045", internal diameter (I.D.). They are usually referred to as Seldinger needles, and are composed of an outer sheath upon which is a controllable flange. There is an inner cutting needle with a bore and finally a sharp stylette. (Fig. 2.)

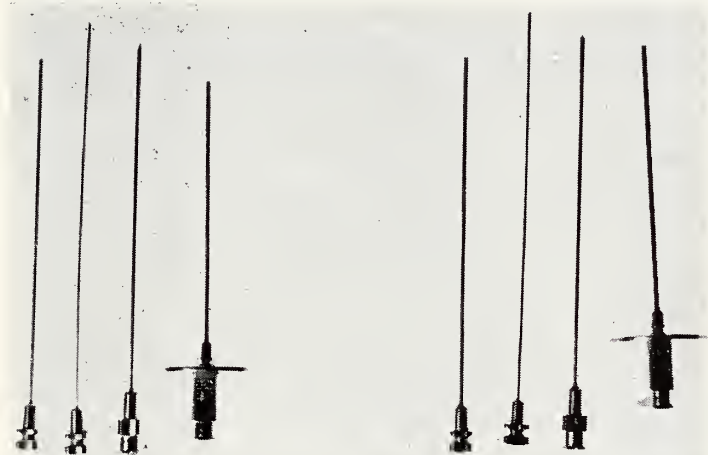


Fig. 2. Dismantled "Seldinger Needles" used, .035" on the left, .045" on the right.

As a source of confusion, numbers of various dimensions have been used to indicate sizes of needles, wires, catheters, etc. The term PE 205 and PE 160 are not measurements, but are arbitrary production numbers of the manufacturer. (Graphs 1 and 2.)

The two graphs show the relationship between inches, centimeters and French sizes. It should be remembered that one must refer these figures to the inner and outer diameters of objects. In general it is felt that outer diameters are the more important reference point, since it is this size that is

compromising the luminal capacity of any vessel.

The guide wires that are used are of several varieties. In general, we have preferred the inner core of the flexible wires be firmly fixed to the outer winding at its ends. Fracturing of the outer winding and loss within the vascular system can be a serious complication. Again the wires are of the size corresponding to the needles, being .035" and .045" outer diameter (O.D.).

Tortuosity and irregular luminal defects of arteries are particularly suitable to J-shaped wires. (Fig. 3.)

Catheters

The catheters are either of polyethylene or teflon, and vary in size from .070" to .047" inner diameter (I.D.). Those that are most commonly used in this department are either the .070" or .071" I.D. with an outer diameter (O.D.) of .109" and .093" respectively. The difference in these latter two is obviously wall thickness. Though the latter is a thin wall, satisfactory delivery rates of contrast material have been obtained. Rarely are aortographic catheters smaller than the least of these. Occasionally, in children, smaller dimensions are utilized; a subject to which other authors are more experienced. The lengths of catheters can vary but tend to be standardized at 50, 80, and 120 cm.

These catheters are arranged in various shapes and with side holes, usually 3-4 in number.³ Catheter material is purchased from the distributor in bulk and final processing and shaping performed by ourselves, though there are no objections to having this performed by professional persons. We have become accustomed to making the size and shape of loops ourselves. The loops vary in diameter according to the expected I.D. of the aorta. Double loops are formed in some for ascending aortographic work. (Fig. 4.) The purpose is to prevent, as much as possible, the uncoiling that occurs at the time of injection. Inadvertent in-



Fig. 3. Two guide wires, showing windings. J-wire on the right.

jections of large volumes of contrast material into cerebral vessels, coronaries and intracardiac chambers may create serious complications. The loop also serves to deliver the bolus of contrast material within a concentrated area.

Some of the catheters are shaped specifically for selective work, thus certain curves are designed for renals and other abdominal vessels, the in-nominate, etc. (Fig. 5.) Lately, the authors have had considerable success with the use of straight catheters in association with an obturator in aortographic work. (Fig. 6.) This technique is not new and has certain appealing features. The obturator is welded to a long, thin but durable wire. The fixation of the wire is external to the patient. This eliminates the possibility of losing the obturator within the patient in case of catheter rupture.



Fig. 4. Two looped catheters shown. Double loops on left used in ascending aortography.

As aortography became an acceptably safe and informative procedure, interest grew into the development of selective arteriography of individual arteries. Mention has been made of preformed catheters for this work. Judkins has contributed to this field in performing coronary arteriography⁴; others refer to "head hunter" catheters for cerebral vascular studies. These procedures have the disadvantage of the use of intra-catheter wires and the necessity, on occasion, of multiple insertions of preformed catheters. It may lead to prolongation of the examination and added trauma to the site of arterial puncture.

A very useful and versatile instrument has been introduced as a guided catheter. Though there have been a variety of systems devised, the one most successful in our hands is referred to as the Medi-tech



Fig. 5. Various types of preformed catheters for selective injections.

system.* It offers the advantage of eliminating the intra-catheter wire and allows the operator to manipulate the system with a constant drip of heparinized saline. This prevents the possibility of foreign material and blood clot from being inadvertently injected. The system offers a maximum degree of control of the tip of the catheter in all parameters. Torque control by virtue of the guide wires in the wall of the catheter eliminates twisting of the catheter at the puncture site.

Technique of Arteriography

After it has been determined that a patient would benefit by the procedure without an undue risk of complications, attention is given to the most accessible ap-

*Medi-Tech, incorporated, Belmont, Mass.

proach consistent with the area to be investigated.

The following remarks, impressions, and hence principles have been obtained by considering the experience of other investigators and of our own material, consisting of 2,174 cases over a period of five years.

We have no suggestions regarding the Seldinger technique of arterial puncture with the insertion of a flexible wire. The vessels peripheral to the puncture are palpated and marked. This abets the operator in caring for the puncture site following the procedure. The intra-arterial wire is passed through the needle and advanced to the abdominal aorta under fluroscopy to make sure of its patency. Tortuosity and partial obstructions are noted; in case of the latter, the J-wire may be of use. At no time is the intra-arterial wire forced. Constant fluoroscopic visualization is necessary. It is often discovered that in elderly individuals the right common iliac is very tortuous but patent. This does make for difficulties in advancing and control of the catheter. It may be elected to use the left side since tortuosity is less common than on the right. The wire is then withdrawn to the level of the sacro-iliac joint and the needle removed, thereby assuring sufficient wire length external to the groin for the placement of the catheter without further motion of the wire or upon the puncture wound in the artery. The catheter is threaded over the wire and introduced into the artery. From the time the needle is removed until the catheter is in the artery, hemorrhage is controlled by digital pressure.

Having dealt with catheter insertions into arteries, various technical factors arise at different sites of catheter positions.

Thoracic aortography has a few points that need mentioning. Perhaps the highest incidence of serious complications occurs in patients having ascending aortography. These are usually cerebral in nature but closely challenged by cardiac problems. In aortic root injections it has been our intent to refrain from crossing the aortic valve with any type of instrumentation. Such an event is inviting cardiac arrhythmias which can be of serious consequence when unrecognized and untreated. A position midway between the aortic root and origin of innominate artery for looped catheters is chosen. The exit holes are directed caudad

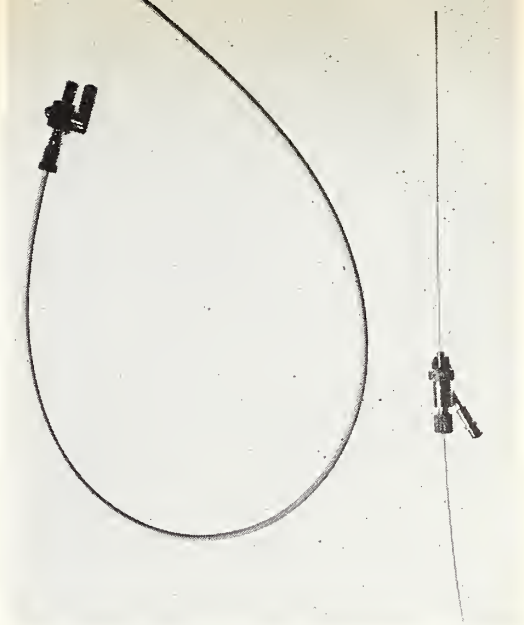


Fig. 6. Straight catheter with obturator used for aortography.

away from the cardiac structures and re-coiling is away from the origins of great vessels. On double loops, the exit holes are in the first or proximal loop, usually 3-4 in number. Another point to mention is that the catheter should be long enough to traverse the tortuosity of the aorta in the elderly and we tend to push the catheter into position so that the catheter lies against the lateral wall of the descending aorta as well as against the roof of the arch of the aorta. The size of the catheter is determined by each system set up. We have been satisfied with the deposition of 60 cc of contrast material within 2 sec. This has required with our equipment a French 8 catheter or its equivalent .045-.052 I.D.

Lately, the authors have by virtue of their desire to be rid of the disadvantages of loops, namely uncoiling, intraventricular injection, inadvertent great vessel injection, and the difficulty of passing loops into the femoral artery, used the following system. The catheter used is straight and of the size stated above. There are multiple side holes concentrated within 2-3 cm. of the end of the catheter. With the catheter placed in the mid-ascending aorta, an obturator is passed down the catheter which occludes the end hole. On injection, the contrast material exits from the side holes in a concentrated bolus. Due to the possibility of rupture of the catheter and loss of the metallic occluder into the vascular system, the occluder is welded to a long thin wire and the wire is locked into position



Fig. 7. Examples of ascending aortography with obturated catheter.

by a vise mechanism external to the patient. (Fig. 7.)

The possibility of cardiac complications, particularly arrhythmia and/or cardiac arrest, have prompted our procedures, above the level of the diaphragm, to be monitored by a continuous EKG.

There are no particular problems with descending aortographic procedures that need mention. As has been described by other authors, dissecting aneurysm is examined by ascending aortography as described, but in addition, a descending aortogram is performed to visualize the distal end of the dissection or re-entry point. Not infrequently, the dissection extends considerably, making surgery quite difficult.

Abdominal aortographic procedures have been the subject of discussion by many authors and described adequately.⁵ Renal

artery disease in renal hypertension can be simulated by catheter or wire manipulation within the renal artery. Thus, it is usual that a "flush" aortogram is obtained before selection studies are entertained. Preferably the films show no filling of the celiac axis or superior mesenteric artery. Either a single looped catheter with the exit holes directed in and down or a straight obturated catheter is employed. (Fig. 8.)

The position is determined at fluoroscopy by a small test injection. A dose of contrast material from 25-45 cc is quite adequate for the final filming.

For levels above this to fill the celiac and superior mesenteric may require catheter sizes of greater size than for renals. The drainoff of these vessels can be considerable.

Attention at this point is given to trans-

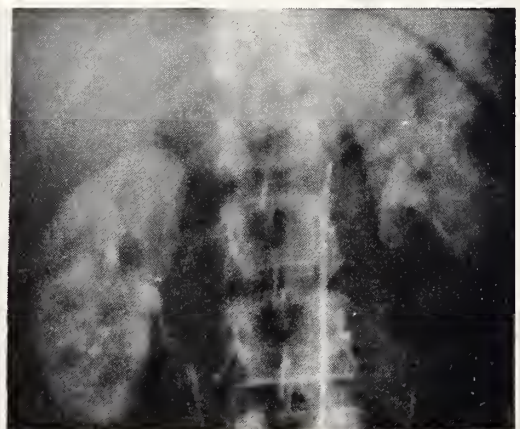


Fig. 8. Examples of "Flush" aortography for renal arteries.

lumbar aortography, a very simple, safe and adequate procedure. Much of our work is upon individuals of advanced age and compromised circulation of the lower extremities. Catheter placement from below can be difficult or impossible. The procedure should be painless using sufficient amounts of local anesthesia. The needle is inserted from the back on the left side, 7-10 cm from the spinous processes and the needle is below the twelfth rib, directed 45° cephalad and 45% to the midline. An attempt is made to enter the aorta at the level of the first lumbar and twelfth thoracic vertebrae utilizing fluoroscopic control to avoid putting the needle into a branch of the aorta. When the flow of blood is observed, a small test dose is given slowly under fluoroscopic observation. Subintimal or extravasation then is held to small innocuous amounts. The insertion of an additional needle at a level determined by the original aortogram can then be entertained.

A frequent request is visualization of vascular circulation of the posterior cranial fossa. This area is supplied by the vertebral basilar artery system. Direct puncture or selective catheterization of these vessels can in the first instance be difficult and in the second rarely necessary. Even momentary ischemia of structures supplied by these vessels is undesirable. Satisfactory arterial filming can be obtained by either the simple technique of right or left retrograde brachial injections or selective catheterization and injection of either subclavian artery, from which the vertebral arises. In the former instance 45 cc in 1.5 secs. is adequate. While 20-25 cc in 2 sec. in the latter.

Some mention should be made about the axillary approach to the aorta. At times the tortuosity of the innominate artery is a hindrance. In patients with an elevated arch, the angle of take-off of the innominate from the arch, makes entry into the ascending aorta difficult.⁶ It is better approached from the left. The incidence of hematomas of considerable size and brachial plexus injury dictates caution in considering this approach.

Inasmuch as the anatomical arrangements of branches of the aorta are the same from patient to patient, it makes the appli-

cation of preformed catheter techniques quite satisfactory. Our set-up has catheters with preformed shapes for all major vessels arising from the aorta. These may be end hole catheters but additional holes may be used. Experience has dictated that end hole catheters only be employed in any major vessel to the cranium. The length of the catheter makes it difficult to be sure that no clots have formed between the end and last hole of the catheter.

There are occasions when aortography is desired prior to selective injections. Care should be given that the catheter used in these situations be of the same outer dimensions or the larger of the two be used last, and excessive bleeding at the puncture site is thus avoided.

As a final point, stress is made of the necessity to have multiple and variable types and sizes of catheters. Having equipment for aortography available as well as selective arterial injections at each examination increases one's versatility, and produces better and more complete examinations. There is a tendency to terminate the procedure before all possible information is obtained. As long as the patient is not being harmed in any way, there is no need to bypass additional procedures. An arterial puncture and catheter studies are preferably a one incident occasion.

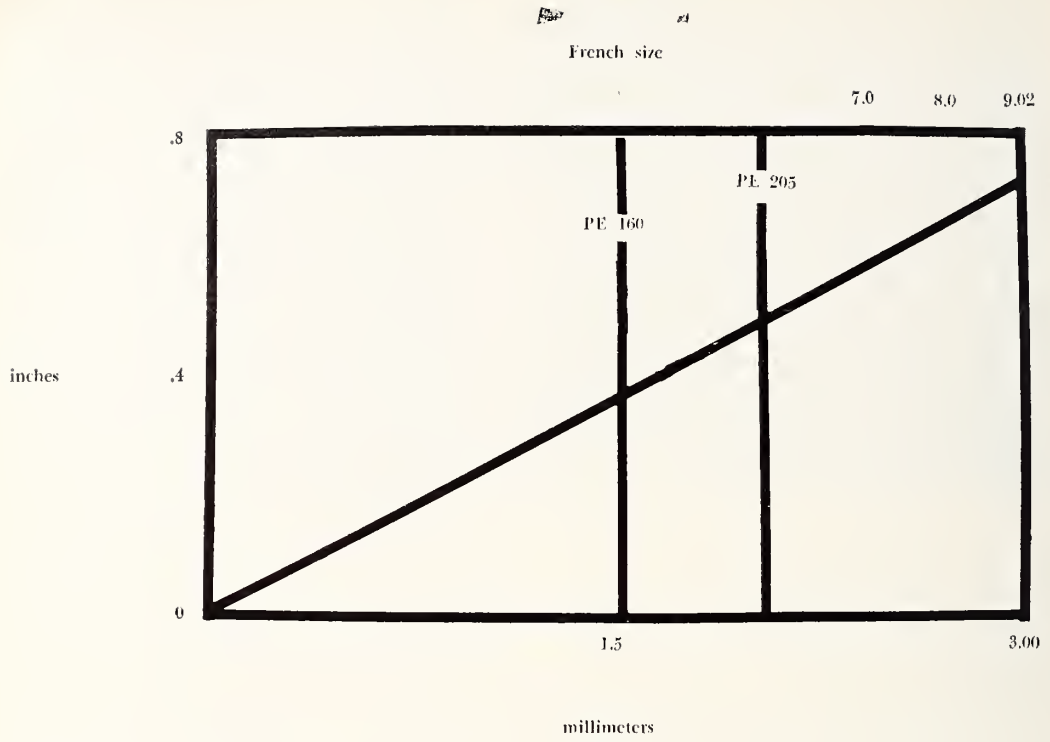
Summary

This paper attempts to present a clinical approach to patients being considered for arteriography. Techniques and the reasons for these are presented as well as the types of equipment. Indications and contraindications are also discussed. ◀

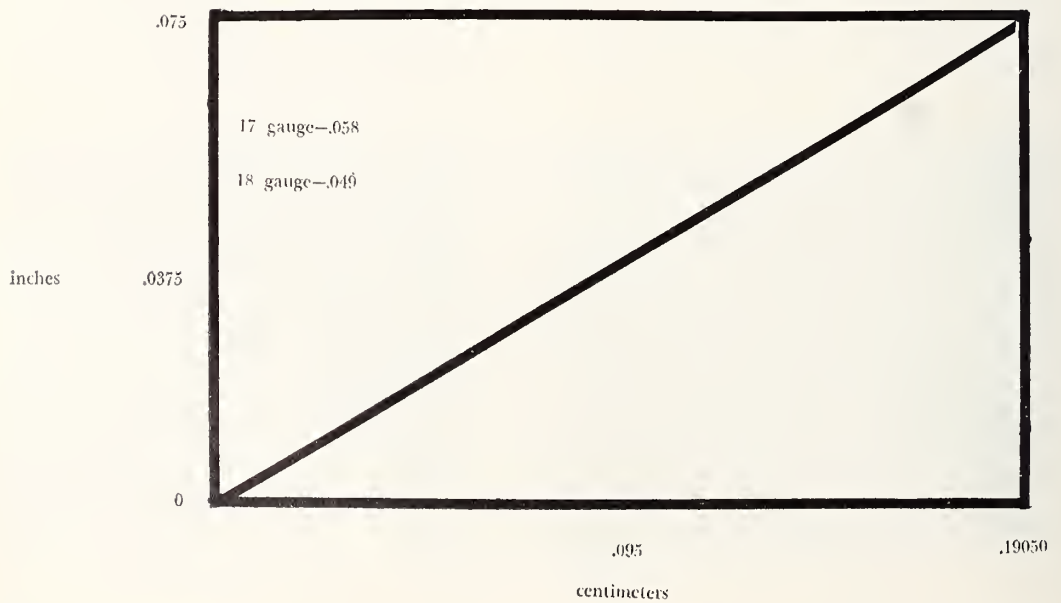
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Graph 1



Graph 2





THE VIEW BOX

BY LEON LOVE, M.D.

*Director, Department of Radiology, Loyola University Hospital
and Chairman, Department of Radiology, Loyola University
Stritch School of Medicine*

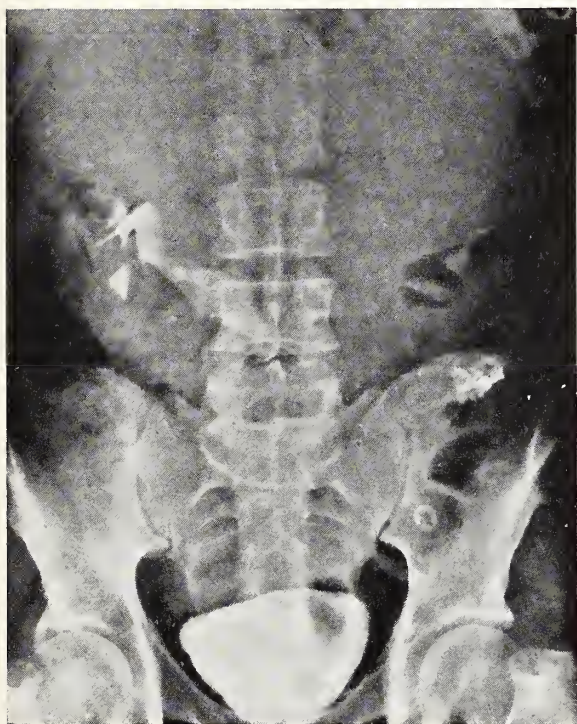


Figure 1

This is a 32-year-old male who entered with a chief complaint of gradually increasing mass in the left side of the abdomen for the past three months. He had reported previous bouts of fever and occasional burning on urination. Physical examination revealed a fairly smooth, deep-seated mass in the left upper quadrant. No other abnormalities were noted. The urine revealed 5-7 WBC per hipower field. What's your diagnosis?

1. Hydronephrosis
2. Hypernephroma
3. Non-functioning left half of a horseshoe kidney
4. Pararenal pseudocyst

(Answer on page 278)

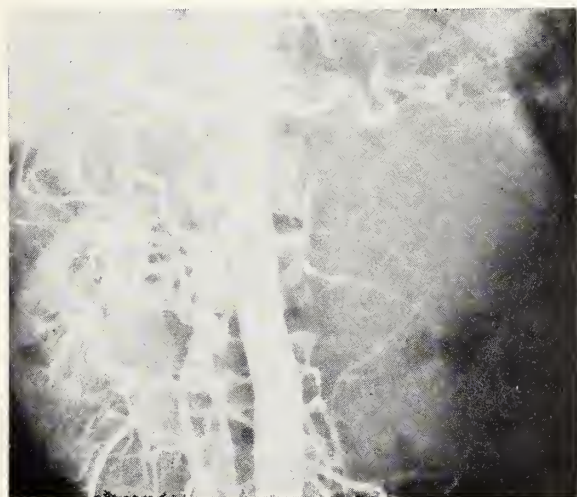


Figure 2



Figure 3

Meteorologic factors

In the fallout

Of pollens and molds

BY HERMAN A. HEISE, M.D., and EUGENIA R. HEISE, M.T./COLORADO

Abstract

Ordinarily the concentration of pollen and mold spores is determined by counting the particles which settle on a sticky slide over a period of 24 hours. However, the airplane can collect as many particles in 30 seconds as could be obtained by gravity method in 24 hours. These "spot checks" enabled us to study the mechanism of fallout, including the influence of bodies of water, wind direction and velocity, and the effect of clouds, smoke and ground fog. In the final analysis, the *lapse rate*, the changes of temperature with altitude, is the most important factor in fallout. Our findings indicate that we can prophesy pollen counts as accurately as tomorrow's weather. Yesterday's gravity counts may be interesting, but tomorrow's estimate has practical value.

Ordinarily the published and broadcast pollen counts are obtained by counting the particles which fall upon a glass slide exposed to the atmosphere for 24 hours. The number of pollen grains in an area of one square centimeter is then interpreted as the number per cubic yard. This method has some shortcomings which are obvious to the person who is allergic

to these particles. A 24 hour exposure may involve a count of a mere 100 pollen grains and yet the hay fever victim may feel worse than when the count is five times as great. This may be explained by the fact that the fallout greatly exceeded his threshold for just a few hours but the count was very low the rest of the 24 hour period.

When the airplane is used for collecting pollens, we are able to collect as many solid particles in 30 seconds as would be harvested over a 24 hour period by the ordinary gravity method. Thus, we can evaluate the importance of diurnal and nocturnal variations; the effect of lapse rate; wind velocity and direction; the influence of bodies of water, the importance of clouds, haze layers and smoke; and particularly, the advantage which the city has over the surrounding rural areas for the hay fever and asthmatic patient.

Although knowledge of yesterday's pollen and mold count is interesting enough for broadcasting in newspapers, and by radio and television, we now have sufficient information to prophesy the far more important knowledge of what may be expected *tomorrow*; and estimates concerning the *times* of greatest fallout are also feasible. The study also convinces us that in spite of the well worn statement that we are unable to do anything about the weather, we nevertheless have some control

(Commentary accompanying film shown at 1970 annual meeting of Illinois State Medical Society.)

over the factors affecting fallout.

In the movie we see the solid particles carried aloft by the unstable, hot surface air on a sunny day. Their upward journey is halted when they reach the haze or cloud layer. This cloud layer occurs at the altitude where the temperature and dew point meet.

All light plane pilots know that rough unstable air is often encountered when flying low over a city in the early morning after a cold night. This condition is due to the warmth of the city. What they don't see is that the air over the city particularly to the *leeward* side contains about one tenth as many pollen grains as are found at the same altitude on the windward side.

Effect of Bodies of Water

We have also encountered similar turbulence when flying over small lakes, in the fall of the year when the water is warmer than the land. The warm lake has the same effect on the distribution of pollens as the warm city.

The effect of Lake Michigan on pollen counts near the western shore is tremendous. On a typical hot afternoon in the fall, a narrow band of cumulus clouds forms parallel with the shoreline, about five to fifty miles inland. These clouds are practically stationary, being formed where the prevailing west wind meets the cooler air which comes off the lake. This cool air is replacing the rising hot air over the land. The cumulus clouds mark the barrier for the particles which have been carried many miles by the west wind. Pollen counts made by flying through these clouds are extremely high. At these times the hay fever victim living within a few miles from the lake shore is relieved of most of his symptoms as long as the clean east wind is blowing.

At night these conditions are reversed. The cumulus clouds which had dammed back the solid particles now disappear, and when the earth near the shoreline has lost enough heat by radiation to make it cooler than the water of the lake, the now stable air over the land dumps its pollens and molds along the shore and many miles inland. The hay fever sufferer will then, almost invariably, blame the "dampness" for his symptoms.*

We have demonstrable evidence of unstable air which occurs on a 10°F. below

zero day when the water of Lake Michigan is 33°F. Although this phenomenon is not directly related to the fallout of pollens, it is an interesting experience to actually see the ghost-like masses of ice crystals dancing when the cold west wind meets the moisture over the warmer water.

Thunderstorms have a profound effect on the hay fever sufferer. Although the downpour of rain may clear the air, the storm itself is like a huge bonfire causing tremendous up-drafts, with gusty winds racing over the dry land to feed the "fire". These winds pick up the pollen grains which plague the sensitive persons.

Comment

Our observations would be of little value if we were powerless to do something about them. It is of course obvious that the hay fever sufferer should keep his windows closed at night, and avoid traveling fast in too well ventilated vehicles particularly in the early morning hours. He should also avoid being near bodies of water when the water is warmer than the land. He will be better off in the warmer city than the cooler country; better when the night air is unstable, which occurs with cloud cover or smoke. However, his worst enemy is ground fog, since the moisture often embodies the concentrated supply of solid particles which had accumulated in the air and particularly in the clouds during the day. The knowledge of the factors influencing fallout makes it possible to estimate the next day's pollen count with the same accuracy that we can prophesy tomorrow's weather.

The concentration of ragweed pollen, which is the greatest offender in fall hay fever, varies according to a basic pattern in Milwaukee. There is a slow rise in the numbers of particles beginning in early August, reaching its peak in early September and then fading away until the end of the month. This basic pattern is affected unfavorably by hot strong south winds during the day with clear sky at night, rapid cooling of the ground and early morning

**The mechanism causing the dumping of pollen grains and mold spores near the shores of bodies of water was discussed at an International Seminar of Paleontologists held at the University of Arizona. At that time we were told that paleontologists had known for years that their best hunting grounds for fossilized pollens and molds had been near extinct bodies of water. The explanation for this phenomenon had heretofore eluded them.*

(Continued on page 277)

NEW

PHARMACEUTICAL

SPECIALTIES

by Paul deHaen

For detailed information regarding indications, dosage, contraindications, and adverse reactions, refer to the manufacturer's package insert or brochure.

Single Chemicals: Drugs not previously known, including new salts.

Duplicate Single Products: Drugs marketed by more than one manufacturer.

Combination Products: Drugs consisting of two or more active ingredients.

New Dosage Forms: Of a previously introduced product.

A New Drug Application has been granted by the U.S. Food and Drug Administration for the following new drugs.

PERGONAL Fertility Agent

Manufacturer: Cutter

KAFOCIN PULVULES Antibiotic

Manufacturer: Lilly

Nonproprietary Name: Cephaloglycin dihydrate

HIPPUTOPE Diagnostic-Contrast Media

Manufacturer: Squibb

Nonproprietary Name: Sodium iodohippurate

CLEOCIN HC1 Antibiotic

Manufacturer: Upjohn

Nonproprietary Name: Clindamycin HC1 (USAN)

Formerly: Clinimycin (USAN)

NEW SINGLE CHEMICALS

DALMANE Sedatives & Hypnotics-Nonbarbiturate R

Manufacturer: Roche

Nonproprietary Name: Flurazepam HC1 (USAN)

Indications: Insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening.

Contraindications: Hypersensitivity to the drug. In pregnant women weigh potential benefits against possible hazard to mother and child. Not recommended for persons under 15.

Dosage: Usual adult dosage: 30 mg. before retiring

Supplied: Capsules, 15 and 30 mg.

DOPAR R

Manufacturer: Eaton

LARODOPA R

Manufacturer: Roche

Nonproprietary Name: Levodopa (USAN): Muscle Relaxants-Parkinsonism L-Dopa

Indications: Treatment of Parkinson's disease and syndrome.

Contraindications: Evidence of uncompensated endocrine, renal, hepatic cardiovascular or pulmonary disease, narrow angle glaucoma, blood dyscrasias and hypersensitivity to the drug. Do not give when a sympathomimetic amine is contraindicated. Avoid concomitant administration with MAO inhibitors and discontinue inhibitors two weeks prior to levodopa therapy.

Dosage: Usual initial dose, 0.5 to 1.0 gm. daily. Dose must be carefully titrated for individual patient.

Supplied: Capsules, 100, 250 and 500 mg. (Eaton) Tablets and capsules, 250 and 500 mg. (Roche)

INAPSINE ATARAXICS R

Manufacturer: McNeil

Nonproprietary Name: Droperidol (USAN)

Dehydrobenzoperidol

Indications: Preoperatively, during induction, and maintenance for sedation or tranquilization. Reduction of incidence of nausea and vomiting. Tranquilizing supplement in general or regional anesthesia.

Contraindications: Hypersensitivity to the drug

Dosage: Individualized

Supplied: Ampuls, 2 and 5 cc, each cc contains 2.5 mg.

DUPLICATE SINGLE PRODUCTS

BETAPEN-VK Penicillin & Derivatives R

Manufacturer: Bristol

Nonproprietary Name: Penicillin phenoxymethyl potassium (USP)

Indications: Treatment of infections due to susceptible organisms.

Contraindications: Hypersensitivity to any of the penicillins.

Dosage: Usual dosage for adults and children: 125 t.i.d. to 500 mg. every 4 hrs.

Usual infant dose: 50 mg./kg. t.i.d.

Supplied: Solution, 125 and 250 mg./5 cc.

EPINAL Eye Preparations R

Manufacturer: Alcon

Nonproprietary Name: Epinephrine as borate complex

Indications: Lowering intraocular pressure in treatment of open-angle glaucoma

Contraindications: Narrow-angle glaucoma

Dosage: Usual dosage: One drop in the eye(s) once or twice daily.

Supplied: Solution—0.5% and 1.0%

GVS VAGINAL INSERTS

Antiinfectives-Vaginal

Manufacturer: Savage

Nonproprietary Name: Gentian violet

Indications: Vaginitis due to *Candida albicans* (moniliasis)

Contraindications: Hypersensitivity to the drug

Dosage: One GVS insert daily, preferably before retiring, for 12 days

Supplied: Vaginal inserts

STEMEX Corticoids R

Manufacturer: Syntex

Nonproprietary Name: Paramethasone acetate (ND)

Indication: Wide variety of collagen, allergic and hematologic diseases, dermatologic and miscellaneous disorders.

Contraindications: Active or questionably arrested tuberculosis, psychoses or herpes simplex of the eye, except in acute life-threatening disorders. Careful clinical judgment is required in presence of diabetes mellitus, active or latent peptic ulcer, acute or chronic infection. Pregnancy particularly during the first trimester.

Dosage: Individualized according to severity of disease and patient response.

Supplied: Tablets, 2 mg.

COMBINATION PRODUCTS

POLIOMYELITIS VACCINE Biological R
(Purified)

Composition: Type 1 (Mahoney), Type 2 (M.E.F. 1) and Type 3 (Saukett)
Manufacturer: Connaught Medical Research Laboratories, Toronto, Canada
Distributor: Parke-Davis
Indications: Prevention of Poliomyelitis
Contraindications: Defer immunization in presence of active infection or acute respiratory disease, and in individuals receiving corticosteroid or other immunodepressant therapy. Hypersensitivity to streptomycin or neomycin.
Dosage: s.c. or i.m., three 1 cc doses at intervals of 4 weeks or more followed by a booster of 1 cc 6-12 months after the third dose. 1 cc recall doses should be given every 2-3 years.
Supplied: Rubber-stoppered vials, 10 cc

EYE-STREAM Eye Preparations o-t-c
Manufacturer: Alcon
Composition: Sodium chloride
 Potassium chloride

Calcium chloride
 Magnesium chloride
 Sodium citrate
 Sodium acetate

Indications: Balanced salt eye irrigation solution
Contraindications: None mentioned
Supplied: Solution in flexible plastic bottle with one-hand stream dispenser.

NU 'LEVEN PLUS Enzymes-Digestive o-t-c
Manufacturer: Lemmon
Composition: Pepsin 150 mg.
 Pancreatic enzyme concentrate 100 mg.
 Ox bile extract 100 mg.
 Cellulase 10 mg.
Indications: Digestive aid
Contraindications: Biliary tract obstruction or hypersensitivity to any of the ingredients
Dosage: Usually one or two tablets taken with each meal
Supplied: Tablets

New tranquilizer developed for alcohol treatment

A new tranquilizer for the treatment of alcohol dependence, *Serentil*[®] (mesoridazine), has been developed and made available by Sandoz Pharmaceuticals, Hanover, N. J. The new agent offers specific advantages over and above the relief of the anxiety, tension and depression that may precipitate alcohol abuse: these include antiemetic properties, an apparent lack of habituating characteristics or hepatic toxicity, and the availability of both oral and parenteral forms.

In preparation for release of *Serentil*, Sandoz cooperated with the Center of Alcohol Studies, Rutgers University, in a massive statistical survey of alcohol dependence and physicians' attitudes toward the problem, including a state-by-state analysis. From this and other data it was learned, for example, that while Indiana ranks 13th in the total number of alcoholics, it ranks 20th in per capita number. It was also noted that more Indiana physicians (compared with the national average) report

	Rank		Women
	Total no. alcoholics	Per cap. no.	
California	1st	2nd	more
Florida	12th	23rd	more
Illinois	3rd	6th	fewer
Indiana	13th	20th	more
Massachusetts	8th	4th	fewer
Michigan	6th	11th	fewer
Missouri	10th	7th	fewer
New Jersey	7th	10th	more
New York	2nd	5th	more
Ohio	5th	13th	more
Pennsylvania	4th	12th	fewer
Texas	9th	34th	more
Wisconsin	11th	8th	fewer

that at least half their problem drinkers are women.

As part of its program to introduce *Serentil*, Sandoz is offering interested physicians a series of recorded panel discussions with leading authorities on alcohol dependence and its treatment. Also in preparation by Sandoz is an Alcoholic Directory, a state-by-state reference of treatment facilities and other pertinent data.

National association formed For drug sales representatives

NASR, Inc., a national association of sales representatives serving the drug industry has been incorporated and a membership drive initiated, according to Richard S. Strommen, vice president of the new association.

A confidential, national placement service will provide members with opportunity for advancement, periodic salary and fringe benefit surveys, legal services, employer-employee representation and group travel benefits.

The association will maintain offices at 300 N. State Street, Suite 5211, Chicago 60610.

New product

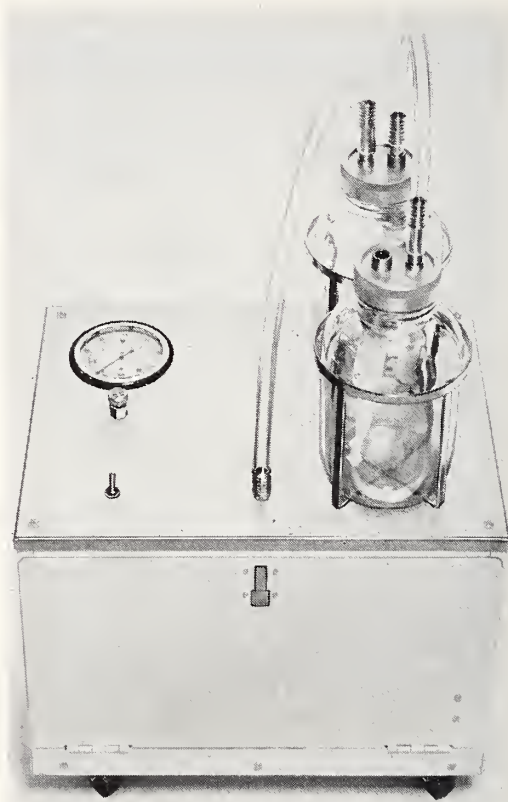
Vacuum curettage unit in compact form

Berkeley Tonometer Co.'s development of the new, compact VC IV, a tabletop version of its popular VC II Vacuum Curettage Unit, is in response to a growing preference for vacuum curettage in therapeutic abortion procedures.

The basic features that have led to the increased demand for the VC II unit have been included in the transition to the compact model. Although not intended as a substitute for the floor-model VC II, or the VC III which includes Berkeley's Vibrodilator™, this smaller version is ideal as a supplementary emergency room unit in large hospitals or wherever the additional features of the larger units are not necessary. The new VC IV unit is priced approximately \$200.00 less than the VC II, and is expected to make expanded use of vacuum curettage procedures possible.

Housed in a rugged steel cabinet and built to the same exacting standards set by Berkeley for all of its vacuum curettage equipment, the VC IV delivers high vacuum with high volumetric capacity. It too utilizes Berkeley's swivel handle and Vacu-ettes™, and provides primary and secondary collection bottles to ensure adequate capacity and give added trap protection against pump carryovers.

New product literature is available. For



information, write BERKELEY TONOMETER CO., 1215 Fourth Street, Berkeley, California 94710.

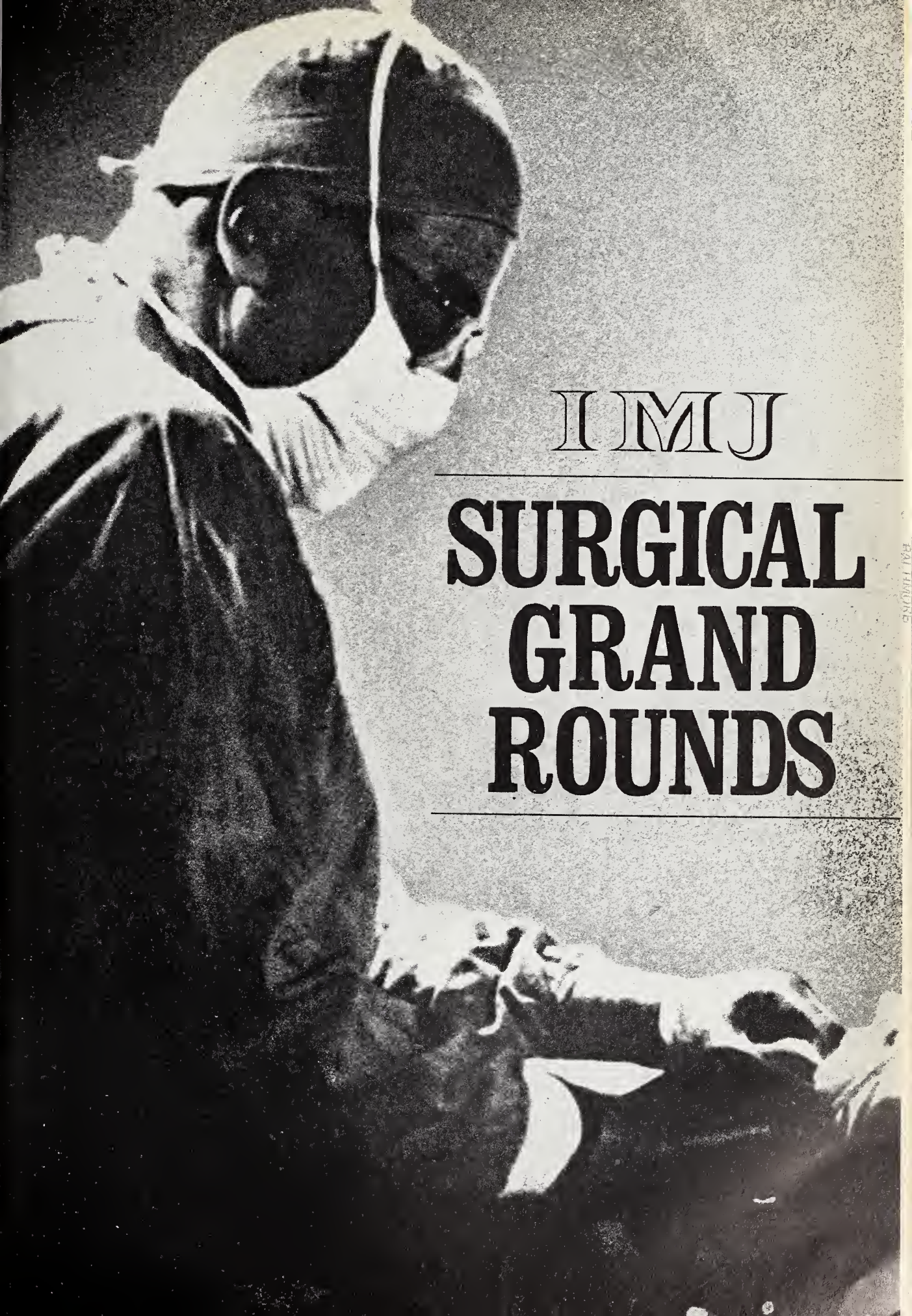
Accent on Living

Handicapped people who are low on funds can get a free subscription to a valuable self-help idea magazine published by a non-profit corporation called ACCENT On Living. "The idea of ACCENT" says editor Ray Cheever, himself in a wheelchair, "is to print only the practical kind of information and ideas that can actually help physically handicapped individuals do things easier."

"A good example is a specific procedure for getting from your wheelchair into your car by yourself and then getting your wheelchair into the car easily." The key is that the ideas in ACCENT come from handicapped people who really know how to do these things because they do them every day and they have become successful."

Special income tax deductions of which a physically handicapped person can take advantage is a feature in the current issue and is an example of the specialized helpful information edited for ACCENT.

Anyone can get information by writing to: The Editor, ACCENT On Living Magazine, P.O. Box 726, Bloomington, Illinois 61701.



IMJ

**SURGICAL
GRAND
ROUNDS**

Surgical Grand Rounds are held weekly on Saturday at 8:00 a.m. in the Offield Auditorium at Passavant Memorial Hospital. Patient presentations from Chicago Wesley Memorial, Passavant Memorial and the Veterans Administration Research Hospitals form the basis of the discussions. This case report was part of the Surgical Grand Rounds held on March 21, 1970.

Neurogenic tumor of the mediastinum

EDITED by JOHN M. BEAL, M.D./CHICAGO

Case Report:

Dr. Maurice Schulten: A 28-year-old, white female, without symptoms was admitted to Passavant Memorial Hospital because a routine chest X-ray revealed a mass in the posterior mediastinum. She denied weight loss, cough, hemoptysis, ex-

posure to tuberculosis or chest pain. She had been smoking three-fourths of a pack of cigarettes every day for eight years.

Past history was not relevant. Review of systems was negative. Physical examination: blood pressure, 120/80; pulse, 88 and

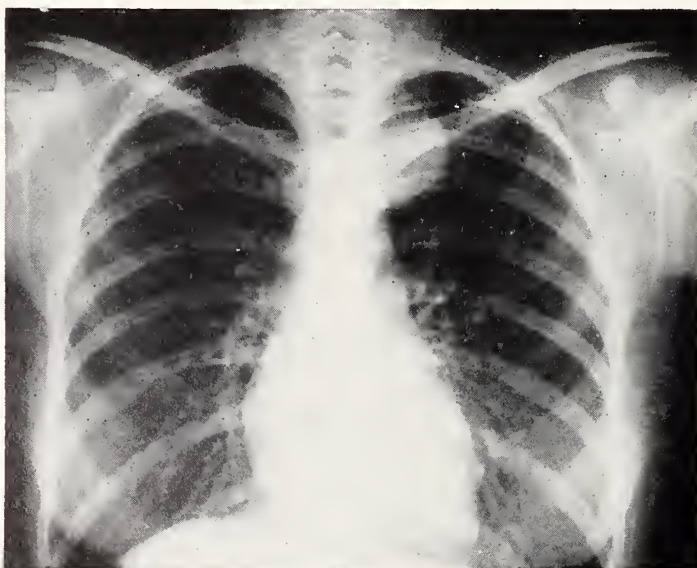


Fig. 1. Chest X-ray demonstrates mass in the left side of the mediastinum.

regular; respirations, 18; temperature, 98.9°. She appeared well-developed, well-nourished, alert, cooperative and without distress. Physical examination was unremarkable. Significant chest findings were absent. Routine laboratory work was within normal limits, and an electrocardiogram was interpreted as normal. Skin tests for coccidioidomycosis, histoplasmosis and tuberculosis were negative. Pulmonary function studies were within normal limits. X-ray examination of the chest was obtained.

Dr. Abram Cannon: This is a beautiful demonstration of a mass presenting from the left side of the mediastinum (Figure 1) and seen well posteriorly on the lateral chest film. Spot films over this area show that this mass is located posteriorly, and the broadest aspect is posterior and then it presents forward, and it is adjacent to the mediastinum (Figures 2, 3). The oblique film shows evidence of erosion of the undersurface of the third rib. I can't see any erosion of the pedicle. This typical location of the bone erosion leads one to think of a benign neurogenic tumor such as a neurofibroma. The roentgen appearance is that of erosion from pressure and not invasion by a malignant process. This is rather frequently seen with neurofibroma and neurilemmomas.

No calcium is present in the mass, but if it were, its presence would also make you think of a benign lesion, although you can get calcium in a large malignant tumor that has undergone necrosis and hemorrhage and then subsequent calcification, but this is not uncommon. When you see cal-



Fig. 3. Lateral view demonstrates the posterior location of the mass.

cium, you should think of a benign lesion. **Dr. Schulten:** A left thoracotomy was performed two days after admission. A mass was found in the left paravertebral gutter and was excised. The patient recovered well and was discharged ten days after operation.

Dr. Arthur Palmer: The specimen was approximately a 5 x 4 x 4 cm. ovoid mass, well encapsulated with a glistening gray capsule. There was a central area of softening with hemorrhage seen on section. (Figure 4). Microscopic examination (Figure 5) showed spindle shaped cells with ovoid nuclei, arranged in bundles. Nuclear palisading is evident, and most of the tumor was composed of the densely arranged Antoni type A tissue, rather than the more loosely arranged Antoni type B tissue seen in some of these tumors. These gross and microscopic features are characteristic of neurilemmoma.

Dr. Schulten: The classical classification of mediastinal tumors is to place them in the anterior, middle, and posterior mediastinum. The posterior mediastinum is actually the two paravertebral gutters and the most common tumor encountered here is of neurogenic derivation. The commonest neurogenic tumor is the neurilemmoma; the next most frequent, the neurofibroma. Neurogenic tumors in this area arise from the intercostal nerves, the sympathetic nerves and ganglia. Rarely, neurogenic tumors may be found in the anterior mediastinum.

In the reported series of mediastinal tumors, the most commonly reported lesions are the neurogenic tumors and these comprise approximately 25% of all tumors. Teratomas and enterogenous cysts are the



Fig. 2. Spot film suggests erosion of undersurface of the third rib.



Fig. 4. Cut surface of tumor demonstrated encapsulation and central area of softening.

other two frequent types of mediastinal tumors.

Specifically, the neurogenic tumors consist of the following categories: neurilemmoma, neurofibroma, ganglioneuroma, neuroblastoma, sympatheticoblastoma, pheochromocytoma, paraganglioma and other more rare benign and malignant neurogenic tumors. The relative frequency of malignancy of all the neurogenic tumors varies from 10-50%. The overall incidence of the various types of tumors is conflicting in the various reports since multiple designations have been utilized for the identical tumors.

By and large, the vast majority of the neurogenic tumors are asymptomatic. The smaller number which do present with clinical symptoms are most often malignant. Occasionally, however, a benign tumor, because of its size or location, especially with extension into the vertebral foramen, may produce symptoms related to the cord or nerve root compression.

In an attempt to better understand these tumors it is wise to separate them into tumors in the adult and tumors in the child. In the adult, most are benign tumors and neurilemmomas, and the remainder are neurofibromas. The neurilemmoma is a tumor composed of Schwann cells and the neurofibromas consist of all the elements of the nervous tissue. The neurilemmoma is an encapsulated tumor and is very likely to undergo degenerative changes within its substance. The neurofibroma is not encapsulated and degeneration infrequently, if ever, occurs. Rarely, is it thought that either one of the tumors may undergo malignant degeneration. In children, in addition to these two tumors, neuroblastomas, ganglioneuromas and ganglioneuroblastomas are

frequently found. The neuroblastomas are malignant, and the overall incidence of malignancy in neurogenic tumors in children is over 50%.

Dr. Thomas Shields: As noted by Dr. Schulten, most of the neurogenic tumors seen in adults are neurilemmomas. The vast majority of these are benign. They are asymptomatic and found only on routine roentgen examination of the chest. Occasionally, a dumb-bell type of tumor exists, but their presence has far outweighed their importance because of the fascinating aspect of cord compression. When this occurs, the usual mode of approach is first laminectomy and removal of the intraspinal portion, and then a second procedure to remove the portion within the thoracic cavity.

Normally, in a young adult with a suspected neurogenic tumor, a posteriolateral thoracotomy incision is used through an interspace without sacrificing a rib. The pleura is incised over the mass and the tumor simply is enucleated. In this particular instance, the tumor's origin from the sympathetic chain was quite evident and we took a portion of the chain along with the mass. The one thing to remember is that these tumors are supplied by the systemic circulation and this must be secured properly or there will be postoperative bleeding. We have found the use of metal clips to obtain hemostasis here to be most advantageous.

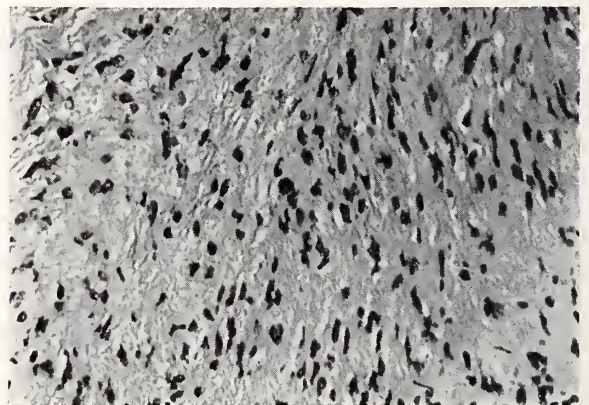


Fig. 5. Microscopic examination demonstrates spindle shaped cells, typical of neurilemmoma.

Generally, these tumors do not recur, but we had one instance where a relatively large lesion, approximately the size of a large grapefruit, recurred three years later following its initial removal. At this time

the lesion was locally nonresectable. However, this was a neurofibroma rather than a neurilemmoma.

With the conflicting reports in the literature, it is my impression that the recurrence of a benign neurogenic tumor in the posterior mediastinum is relatively unusual but may occur in von Recklinghausen's disease. Generally in these instances, the tumor is of the neurofibromatous type.

One of the troubling features when one discusses mediastinal tumors is that tumors are relatively rare and are only infrequently encountered during clinical practice. As a result, the statistics that have been gathered have been accumulated over a long period of time and what might be true in the past really is not true for the present time. About 66% of the neurogenic tumors as reported in the literature are benign and 33% are malignant, but this includes tumors in both children and adults. If one breaks it down into these two age groups, one finds only about 10-20% are malignant in adults, whereas in children, about 55% are malignant. By and large in children, the major malignant tumor is the neuroblastoma or, less frequently, the maturing neuroblastoma, which may run a malignant course.

The interesting thing in children is that the neuroblastomas in the chest are frequently associated with neuroblastomas in the retroperitoneal area. In 56 children with neurogenic tumors recorded in the Johns Hopkins series, in only 13 of them was the tumor isolated within the thoracic cage. In this series, the most common tho-

racic neurogenic tumor was the ganglioneuroma. The other major lesion was the neuroblastoma or one of its variants.

One interesting feature which was noted in this particular group of children was that, regardless of the histologic maturity of the neuroblastoma, the tumor could produce catecholamines and the excretion product, VMA could be discovered in the urine. In these children, the excessive production of the catecholamine was associated with one of two syndromes. The patient may present with diarrhea and abdominal distention, or may present with hypertension, flushing and sweating. Both syndromes disappear with removal of the tumor.

It is believed that neuroblastomas should be removed if possible and then utilize X-ray therapy to the area postoperatively. Occasionally, with widespread metastasis, various courses of chemotherapy are also used. In some of these patients the metastatic lesions will mature and become benign lesions. This is a very interesting biologic phenomenon and the cause of it is unknown.

In the differential diagnosis of neurogenic tumors, the lesion one must consider is the anterior meningocele-meningo-myelocoele. Most often, however, there is a deformity of the vertebral body that is quite obvious and this should tip one off to the diagnosis. When suspected, the diagnosis is confirmed by myelography. Lastly, the occurrence of a chondrosarcoma of the head of the rib may be mentioned in the differential diagnosis. ◀

"Mania" Booklet Available

A comprehensive clinical booklet of current literature on manic-depressive psychosis has been distributed as a professional service to all psychiatrists in the United States by Rowell Laboratories.

Entitled "Mania," the publication features 92 abstracts of the most significant clinical reports on mania and its control published internationally during the past five years.

Evaluation and selection of the articles, and the abstracting were directed and performed by the staff of The Excerpta Medica Foundation.

According to Rowell President T. H. Rowell, Jr., the project "is a part of the professional information program related to company introduction of Lithonate (lithium carbonate) in the treatment of manic-depressive disease."

Lithium carbonate was approved by FDA in April for treatment of the manic phase of manic-depressive illness.

Copies of the booklet are available without charge from the Professional Service Department, Rowell Laboratories, Baudette, Minn., 56623.

The private non-affiliated metropolitan community hospital: Its responsibility To postgraduate

BY LAWRENCE G. KHEDROO, M.D., D.D.S./CHICAGO

The inclusive nature of post-graduate medical education involves and is affected by the hospital environment, the administrative organization, the medical staff, the surrounding community, and the organized content-structure of the resident-intern program. In some of these areas, problems will arise, directly or indirectly affecting training programs.

The community hospital, in reference to continued development and growth, may be presented by a situation in which there are increasing operating costs, a stable but aging medical staff, a deteriorating neighborhood, difficulty of obtaining the services of qualified nursing and paramedical personnel, a need for replacing worn-out equipment, and an inability to attract newer and younger practitioners of medicine.

- a. The steady increase in operating costs has had to be reflected in the increasing cost of daily medical care. The private community hospital, depending for its fiscal solvency on service rendered for fee, must depend on collections of monies for these services and show a profit of sufficient size to maintain the physical plant, replace worn-out equipment, and continue in-service educational procedures. A major difference may be noted between the private community hospital and a public hospital institution; the latter is able to have underwritten its fiscal debts by yearly legislative action.
- b. Neighborhood changes will possibly reflect the influx of low-income groups of people, which will not attract the young medical graduates who enter private

- practice each year. These latter will most likely situate in well-established middle or high income communities, which, incidentally, also need medical care. This could be alleviated, in part, if the hospital would initiate a program of hiring young physicians to man certain sections of the hospital, such as the out-patient clinics, the emergency room, the in-service teaching areas, and/or the major medical services. Such a program would give a starting income to the young practitioner and could also be offered to older physicians in the phase of retirement.
- c. The hospital requires additional equipment from year to year, but unlike the equipment bought for research or pilot projects, private institution equipment has to justify the cost and be able to return in service, and above, the cost of installation, maintenance and operation. This limits the variation and sophistication of equipment that a community hospital can buy unless it can be put to work almost immediately.
 - d. The unsafe neighborhoods and inefficient urban transportation renders it difficult to keep members of the nursing profession and other paramedical personnel who are attracted to more stable, clean, safe, attractive neighborhoods,

as related medical education

wherein, incidentally, the salary available may not be the prime consideration.

One of these aforementioned problems would be amenable to solution, because concentrated effort could be applied toward improving the situation. If several or all of these problems occur in a community hospital at the same time, it may be noted that each has its own attrition at the stable base that makes the hospital a viable concern. It is difficult to place priorities as to which problem requires the earliest solution. These situations influence a resident-intern teaching program and modify proportionally the kind of program that the director of medical education can develop for the institution. Needless to say, inadequate financial income, a deteriorating neighborhood, a non-teaching aged medical staff, inadequate nursing care, and modest equipment, will be factors which take away from the opportunity to develop a first-class resident-intern program.

The Administrative Organization

The administration is in a position to be the continuous thread that can link the various programs and projects together. As the center point of all information, the decisions made in the education program are finalized by administration. As the main originator of expenditures for funds, the amount of money available for medical education is finalized by administration. It requires sophistication and a definition of goals to determine the amount of effort expected to give service as related to that expected to foster medical education. Too often the service aspects of a hospital institution, instead of being correlated with teaching, run counter current to the teaching program.

The Medical Staff

Periodic evaluation of delivery to the public of superior medical services by a hospital institution relates to the staff physicians and their qualifications. Good medical care can be a byproduct of continuing post-graduate medical education, if definitive assigned teaching responsibility is considered a requisite for continued staff appointment. In performing as an almost total service organization, the medical staff may tend to forego time for re-evaluation of past performance, and the learning of new techniques. As a corporate body, seeking to fill the need and accommodate the environment, the medical staff should consider investing a certain amount of effort, in reference to time, study, and finances, back into improvement of the application of medical care. The busy medical practitioner and specialist, working long hours in the office and in the hospital, does not always have opportunities available for self-improvement, rest and reflection. The extra time available to the medical practitioner is often reserved, and justly so, to his personal life that revolves around home, family and recreation. Some medical practitioners are much too busy and consistently have such irregular working hours that it is difficult to schedule something as prosaic as an organized review course at a local institution of medical learning or a special course by mail. After a busy 10-12 hour day, there is not much energy or interest remaining in the solitary study of an erudite medical subject.

Lawrence G. Khedroo, M.D., D.D.S., is clinical associate professor in the Department of Anatomy at the University of Illinois Medical Center, and was formerly director of medical education at St. Elizabeth Hospital, Chicago.

Sufficient numbers of talented hard-working physicians in general practice, after ten or fifteen years in their vocation, find that they would like to trim back their medical responsibilities and enter a specialty of their choosing and interest. In the early part of the twentieth century such specialization would often occur, and the physician would then acquire the reputation of being particularly adept at taking care of certain disease processes, and on this basis, his colleagues would refer such indicated patients to him. Out of this developed the image of the specialist, which permitted a more efficient delegation of time spent in the practice of medicine. Hard-working, capable, and sophisticated physicians in general practice have found the way to self-improvement and specialization blocked because of the financial and social penalties necessary to withdraw and enter a residency program. These men have found that there is no way to get certified in a specialty unless the necessary years are taken from a practice. It would be a tremendous stimulus to these men, if instead of being enrolled in full-time residency programs, they could enroll in part-time programs: e.g., a specialty program taking four years to complete could be permitted to be completed in twelve years at one-third the involved time. It would give an opportunity to these physicians to be in the mainstream of medicine, to work in an institution with university affiliation, and to have a goal that they can look forward to and realize.

Where private non-affiliated community hospitals are located within short distances from each other, the merging of some of their facilities and services may be considered: it would permit the use of specialized equipment; it would increase the teaching medical staff faculty and permit post-graduate medical education programs, residencies, and internships to qualify for approval; it would attract specialists in certain categories, for example an endocrinologist, a geneticist, and/or a biomedical engineer; it would make available an increased and varied volume of patients. Specialization in a certain field of medical service by one institution would make this particular service available to the other institutions in the merger. One example would be an artificial kidney team trained in hemodialysis or a cardio-vascular team trained in open heart surgery. In multihospital affiliation,

departmental administrative chairmen need not be dismissed or changed. For each definitive medical service and educational program, one person would have to be responsible in order to coordinate and fuse the basic objectives of each hospital institution. Such an action aimed at improving post-graduate medical education can serve to upgrade the residency and intern programs. Such a medical staff and administrative association requires a spirit of give and take, and should not be entered into without careful, detailed, and intuitive planning.

The Community

The people living in the area which surrounds a metropolitan hospital, through the city officials, civic leaders, and the hospital administration with the direct support of the lay board, should be enjoined to realize the worth of such an institution to the community. Provisions should be made to obviate difficulties which may arise—whatever their origin—in order to maintain friendly relations between the community and the hospital organization. The hospital should not present too authoritarian a posture; conversely, the community should respect organization and service ability.

A method of assuring the hospital of maintaining and rendering service to the nearby community is to have a hospital organization, with suitable members from its various divisions, make a personal survey of the community and meet with the leaders of the community, in this manner getting first hand information. It is conceivable that information given by governmental administrative agencies may not reflect accurately as to timing what the needs are. This type of interchange between the hospital and community leaders will serve to indicate and maintain the sincerity of the medical installation in its effort to be of primary service to the people in the surrounding urban area.

The Resident-Intern Problem

In a non-affiliated, moderate-size, private community hospital, the development of a resident-intern program requires a survey of capabilities and a clear evaluation of attainable goals. To develop such a program, the hospital lay board and administration should be sympathetic toward the

program, and be willing to subsume the costs of this program. A medical staff willing and qualified to teach, adequate housing and recreation facilities, sufficient and varied clinical material as to out-patients and in-patients, and qualified laboratory, roentgenographic, and social services are also necessary components. The program must initiate from the medical staff, require medical staff participation, and the teaching responsibility for the program must be directly met by the medical staff. Often a medical staff abrogates its responsibilities for the program and considers that the administration or para-medical personnel should handle day-to-day affairs of a resident-intern program. When this occurs, the service aspects of the program tend to take precedence over the teaching aspects. Those members of the medical staff qualified to teach the separate categories of medical knowledge should be enlisted into the program and be given time, remuneration, authority, and a formal appointment, in order to upgrade the program and give it the necessary prestige. In those categories of medical knowledge which are not covered by the training of the medical staff, special speakers, teachers, and demonstrations should be supplied so that the resident and intern in the program acquires the basic sciences and the clinical aspects of his training. To the basic sciences, in addition to the classic divisions of anatomy, physiology, pathology, biochemistry, pharmacology, and bacteriology, should be added genetics, biophysics, bioengineering and cytological physiology. In the clinical sciences, the sociological aspects should be stressed so that what is learned can be applied to the locale where the doctor of the future wishes to settle and render medical service. It is best to have a single person in charge of the entire program—a physician with a background in clinical medicine and teaching. In addition to organizing such a training program and having it qualified and approved, the resident-intern program requires publicity so that medical school graduates, national and international, may be cognizant of this program. An out-patient clinic, geared to serve the needs of the community, affiliation with a local medical school, if this is possible, and the infusion of the teaching staff with outside qualified medical personnel, will help to delineate the direction of the pro-

gram. For foreign medical graduates, the social services can do much to orient these visitor-students and to make them feel at home in new surroundings. As these new interns and residents arrive from a foreign country, the hospital and its personnel will be the first impression that the foreign visitor will get of the United States, and the importance of this and the need for a favorable impression cannot be overstressed. Residents and interns, under supervision and with permission, should have access to all private patients so that good patient evaluation work-ups can be performed in order that the clinical material is available for teaching purposes. It will be found that the average patient is well enough informed to recognize that examination by several doctors, in an effort to come to a correct diagnosis, is also an example of increased service and comes very close to being ideal medical care.

The real and projected advantages of a post-graduate training program carry responsibility and repeated evaluation. With the stimulation of teaching and learning, there can be a continual improvement and upgrading of patient diagnosis and treatment. Significantly, it might be considered that a hospital organization which is qualified to teach, will very seldom have the quality of its service questioned; whereby, a hospital organization that does not have a teaching program, may be subject to repeated evaluation of the type of service that it renders. The corollary: if you are good enough to teach, you are good enough to give service.

The private, small, metropolitan hospital which has acquired an improved program in a residency and/or internship must compete with larger institutions to fill its quota. As it often does not have a choice, there is a tendency for the education and credentials committees to approve all applications until the quota is filled. Under these circumstances, it is still desirable to choose an appointee who has the desire to learn and after fulfilling the requirements, to stimulate the post-graduate future medical practitioner to embark on a personal continuing education program. Not every program, however well qualified, has all the teaching and teaching material necessary. The post-graduate trainee must be advised to learn his particular course of study from a broad national view, so that he may

take his certifying examination anywhere with confidence. The corollary: to develop in the future practitioner the desire to be a continuous student of medicine is a prime goal of a medical training program.

Many of the resident-intern programs advertise the non-learning advantages, such as location, recreation, living facilities, salaries, and personal contacts. These latter have importance, to be sure, but certainly should not be the prime consideration of a training program. It is conceivable that some of the best training programs are not in a plush suburban hospital setting, but more likely in a small community hospital, in a small town with an agrarian population; or perhaps in a teeming city, where overcrowding and the effects of close city-dwelling markedly affect the type of disease seen. There is also the philosophical aspect of the resident-intern program, as to what constitutes learning and what constitutes service. Part of learning in a teaching program is to render service, since the future practitioner, in the main, will devote a large part of his time to service to the community and will have to schedule his time for personal enjoyment and recreation as well as learning. These philosophical aspects of the resident-intern training program should be stressed to the applicant in the program. This will help maintain a high standard of applicants, although it may be difficult to fulfill the quota in competition to other more recreationally attractive programs. The corollary: the education committee should organize a set of standards and then maintain them with firmness and determination. It may be pointed out that service is a type of learning: learning to take responsibility, to be unselfish, and to be someone to somebody in a social-conscious world.

The resident-intern program requires that it maintain a reasonable high level of educational quality. In reference to the recent trends in medical education, of flexibility of the content of the teaching program, and in the absence of definitive medical school affiliation, provision can be made for residents and interns to partake of review courses and research projects in the neighboring medical schools and university hospitals. In this manner, sophisticated trends in the newer sciences of genetics, cyto-biology, biomedical engineering and biophysics may be made part of the regular

training program. Residents and interns, accustomed to teaching and service in the clinical aspects of medicine, will have an opportunity to return to the classroom-laboratory in order to gain the atmosphere of learning and reflection which can be more conveniently experienced in the medical schools and the teaching university hospitals. In this manner, the house staff will have an opportunity to leave the "home" hospital for a half-day or day for another medical installation. This type of program can be arranged with the local medical school and university hospitals, and whether it is part of the resident-intern program in the community hospital or whether it is approved, it will serve as a stimulus and enable the community hospital to fill in the possible gaps in its education program. The philosophical basis for this rests with the possibility that no one institution completely covers the field for which it is approved in a special residency or intern program, and its teaching course can be enhanced by such outside programs. These do not necessarily have to be definitive or formal affiliations, but simple agreements between institutions in order to permit a resident and intern to feel that he has a choice of changing some of the content of the program to which he has been primarily assigned. Examples of these are a pediatric residency program in which the resident has an opportunity to learn additional information concerning congenital defects and the relationship to cytogenetics; the orthopedic resident who may acquire an interest in bone tumor pathology and obtain such information at the nearby medical school department of pathology; the rotating internship program which may offer the intern additional training in hematology or bacteriology. The community hospital can arrange for lectures, demonstrations, or grand rounds to be held at stated intervals, with or without monetary remuneration, as the situation may dictate, and for teachers of professorial rank to come to the community hospital and be occasional part-time teachers in the residency-intern program.

Philosophically, in reference to the resident-intern program, it should be decided whether the program should be tailored to the residents and interns that come into the program, or whether the program

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Statute Of limitations in Malpractice Lawsuits

BY FRANK M. PFEIFER, COUNSEL, ISMS

The Supreme Court of Illinois recently handed down a decision in the case of *Lipsey vs. Michael Reese Hospital and Dr. Gerald Menaker*, in which the Statutes of Limitations in malpractice cases is extended and, in some instances, nullified. The law in Illinois, until this decision, was that an action of malpractice had to be commenced within two years after the alleged negligent act took place and if the lawsuit was not filed within this time, it was barred.

Mrs. Lipsey, under the treatment of Dr. Menaker in Michael Reese Hospital, had a lump removed from under her arm and a biopsy was performed by the pathology department of the Hospital with the report that the removed tumor was not malignant. Two and one-half years later Mrs. Lipsey again contacted Dr. Menaker with the same complaint, at which time he removed enlarged lymph nodes from under the plaintiff's arm and a lump from her left breast. The pathology report from the hospital disclosed a malignant condition in both the lymph nodes and the breast.

Mrs. Lipsey then went to a hospital in New York where radical surgery was performed for the removal of her left breast, shoulder and arm. The New York Hospital obtained a frozen section of the lump removed when she was first in Michael Reese Hospital and the pathology department of the New York Hospital pronounced it malignant.

Mrs. Lipsey then brought suit, which was

then more than two years after the removal of the lump and the incorrect diagnosis in the Chicago Hospital, but, was within two years after the discovery of the incorrect diagnosis had been made.

Both the physician and the hospital moved to strike the complaint as being barred by the two year Statute of Limitation, but the Supreme Court, in reversing all prior Illinois law on this subject, held that it would be unrealistic and unfair to bar the cause of action of the injured party before the negligence had been discovered. The Court then specifically held that the lawsuit could be filed any time within two years after the act of negligence became known. This so-called "discovery rule" has been upheld in other jurisdictions but this is the first time that it has been applied in malpractice cases in Illinois.

In all cases before our Supreme Court, either side may ask for a rehearing after a case has been decided. The physician and hospital were given until August 10 to file a petition for such a rehearing. In the opinion of the writer of this article, there is very little chance that such a hearing will be granted and, if this is correct, the decision will become final.

If this decision is not changed on rehearing it will mean that there is no longer any limitation insofar as malpractice is concerned, as lawsuits may be brought at any time within two years, after the alleged act of negligence has been discovered by the patient. The specific holding of the Illinois Supreme Court is that, in a medical malpractice case, the cause of action accrues at the time of the discovery of the negligence and not at the time of its occurrence.

In 1965, the Illinois Legislature added a new section to the Limitations Act, which provided that if in the course of any medical or surgical treatment or operation, any foreign substance was permitted to remain within the body which caused harm, the Statute of Limitations would not begin to run until the negligence was discovered, but the Act further provided that no action could be commenced within ten years after the negligent act. While this Statute is not an issue in this case the courts will, in the future, probably adopt the discovery rule in this, categorically, and eliminate the ten year limitation provision. ◀

The Medical Examining Committee of the Department of Registration and Education of the State of Illinois has recently been the target of rather acrimonious criticism from members of the Illinois State Medical Society¹. It is alleged, among other things, that the Committee is preventing "highly qualified" physicians from entering practice in Illinois because a clinical competence examination is required. Apparently the Committee is not working hard enough, and is processing examinations on a quarterly basis instead of continuously. It is alleged, much to the surprise of the Committee, that other states are making continuous examinations available. The authority for this opinion is not quoted. There have been other criticisms. Most of these are the result of misunderstanding, misinformation, and lack of comprehension of the problems of licensure.

KHS.

Medical

Let's reciprocate

BY GEORGE H. BURKE, M.D./ROCK ISLAND

There is an urgent need to change the procedure for issuing medical licenses by reciprocity in Illinois.

Members of the Rock Island County Medical Society have learned of this need through their efforts to recruit badly needed physicians, and the frustrations they have felt on numerous occasions when they have found that lack of reciprocal licensing was just too big a stumbling block for the fully qualified doctors they were trying to recruit.

I would not have my present associate if he had been required to take an examination for Illinois licensure. As a former associate professor, he was one of the fortunate physicians licensed by eminence in 1969. Originally licensed in New York, in 1944, and subsequently licensed in New Jersey, and West Virginia, he came to Rock Island County highly qualified; yet he has told me flatly that he would not have come if he had been required to take an examination.

My own experience is not unique. Rock Island County has lost doctors because re-

ciprocal licensing is not a reality, and it is quite apparent that many other county societies have suffered the same frustrations. Widespread discontent with the present system was voiced by many delegations at the 1970 ISMS convention. The depth of their sentiments became obvious when the House of Delegates rejected a negative Reference Committee report and adopted a Rock Island County resolution aimed at speeding up licensure by reciprocity.

It is interesting to note that, according to AMA statistics (*JAMA*, June 15, 1970), there are 34 states which will endorse licenses granted by Illinois, yet Illinois will accept those of no other state.

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Licensure

Let's not reciprocate

Licensure Problems in Illinois

By KENNETH H. SCHNEPP, M.D., AND WILLIAM G. MCCARTHY, M.D./SPRINGFIELD

Without going into the history of medical licensure in Illinois, it may be pointed out that the present Act was adopted July 1, 1923. It has been amended in minor matters a number of times but in its basic principles the Act is essentially unchanged since 1923.

The Act provides for the issuing of li-

censes to practice medicine and surgery in all its branches. In addition, it specifically creates licensure for the practice of any system or method of treating human ailments without the use of drugs or medicines and without operative surgery. It should be pointed out that the Medical Practice Act has no jurisdiction over related health fields such as podiatry, dentistry, veterinary medicine, nursing, optometry, pharmacy, physical therapy or psychology.

Two other forms of license have been added to the Act since World War II. The first is a temporary license, which is the practice of medicine in all its branches. It is limited to a specific time and hospital, and is intended to encourage graduates of accredited medical schools to come to Illinois for residency training. These are readily issued to approved hospitals and are controlled and retained by the responsible hospital.

The second form of licensure to be added was the State Hospital Permit. This is granted to employees of the Departments of Mental Health, Public Health, Child and Family Services, and their affiliated train-

Kenneth H. Schnepf, M.D., (not shown), is a Springfield surgeon. He received his M.D. degree from the University of Illinois College of Medicine. A Fellow of the American College of Surgeons and the American Medical Writer's Association, Dr. Schnepf is founder of the *Bulletin of the Sangamon County Medical Society* and the Springfield Medical Library Association. He has also served as a member and chairman of the Medical Examining Committee, State of Illinois, and as a member of the Examining Institute, Federation of State Medical Boards of the United States. **William G. McCarthy, M.D.,** (right) is a general surgeon. He received his M.D. from Loyola. A Fellow of the American College of Surgeons and a Diplomate of the American Board of Surgeons, Dr. McCarthy is secretary of the Illinois Medical Examining Board.



ing facilities. The holder of such a permit is restricted to the institution to which he has been assigned, and theoretically is under the constant scrutiny of a fully licensed individual. The Act encourages such a permit holder to seek full licensure at the earliest opportunity and requires evidence of continuing medical education. Since 1966, holders of such permits have been permitted but two renewals, which in effect, gives six years in which to obtain full licensure.

Throughout the entire Act the term, "in the judgment of the Department" is used. Previous to 1945, the Director of the Department of Registration and Education was a virtual dictator. He could, and frequently did, order licenses issued by reciprocity or examination almost at will, without regard to the opinion of the Medical Examining Committee. As the result of a scandal in which it was alleged that the then Director was in fact profiting financially by issuing licenses to the right people, the Act was amended in 1945, to state that none of the functions, powers, and duties enumerated in the Act could be exercised by the Director, except upon the action of and report in writing of the Medical Examining Committee. This has probably been the most important change in the Act since 1923.

The Civil Administrative Code

Up to this point, the Medical Practice Act has been referred to. Few people, indeed, realize that another Act is important in the licensure procedures of the state. This is the Civil Administrative Code, adopted under Governor Lowden in 1917. This Act created the Department of Registration and Education, and among other things, the Medical Examining Committee. It provided for five licensed doctors of medicine to which could be added by the Director, when necessary, other practitioners in other fields to conduct examinations peculiar to their schools. Since then, a doctor of osteopathy and doctor of chiropractic have been appointed as additional examiners.

It is the duty of this Committee, among other things, to conduct the examinations for licensure four times each year, assemble the grades, and recommend in writing to the Director, the granting of licenses in the various categories. The Committee also is the hearing body for the purpose of sus-

pending or revoking licenses, for cause, and for the purpose of reinstating licenses.

It must be emphasized that the Medical Examining Committee has no administrative function. The Department of Registration and Education (meaning the director) makes all administrative decisions in the enforcement of the Act with the exception of examinations and issuing licenses. All disciplinary actions must originate outside the Medical Examining Committee. In passing, it might be mentioned that membership on this Committee carries no compensation.

Activities During 1968 and 1969

With this brief review, it might be of interest to scrutinize the activities of the Medical Examining Committee during the past two years. During this two-year-period the Committee met 23 times. Eight of these meetings were to conduct examinations, but other business also was transacted. In addition to these full meetings, partial or committee meetings were held on six occasions for specific purposes. In addition to these, individual interviews for National Board and FLEX interviews were held in Harrisburg, Springfield, Galesburg, Pontiac, Dolton and Chicago. The total number of these interviews is unknown, but 29 were held in 1969, in Springfield alone.

During the two year period, 570 licenses were issued by endorsement of a National Board Certificate, 55 licenses were issued by "emminence," 11 were issued by endorsement of FLEX examinations taken in another state, and there were 34 restorations of licenses that had lapsed. This was a total of 670 licenses issued by endorsement and interview.

Also during this two year period, in eight examinations, 342 applicants were granted licenses by full examination. This group was almost entirely made up of foreign graduates. (When it is necessary to administer a full examination to an American graduate at the present time, it usually means he previously failed the National Board).

The remaining group of licentiates includes the so-called "reciprocity" applicant. These are the applicants, licensed in another state, that are given a clinical examination or test of clinical competence before reciprocity is granted. No one is quite sure when this practice began but it has, at least,

been the custom for the past 35 years. At one time, this was conducted in Cook County Hospital using actual patients of the hospital. However, changes in the hospital population, coupled with the greatly increased number of applicants, led to change, and beginning in 1964, the Committee adopted part III of the National Board as its measure of clinical competence. It might be mentioned that the grading is done by National Board standards, but in this examination only, the committee does not adhere to a passing grade of 75. For some time this cut-off point has been 73.5%. The authority for this is Sec. 13, paragraph 7 of the Medical Practice Act which states:

"In the exercise of its discretion under this Section, the Department is empowered to consider and evaluate each applicant on an individual basis. It may take into account, among other things, the extent to which there is or is not available to the Department, authentic and definitive information concerning the quality of medical education and clinical training which the applicant has had. As amended by act approved August 11, 1967."

Reciprocity Procedures

The questions most often asked are something like these: Why require a test of clinical competence? Why not simply reciprocate with another state willing to reciprocate with Illinois?

There are a great many reasons why the State of Illinois cannot do this and why it is necessary to conduct some sort of screening procedure.

What is forgotten is the undeniable fact that a license to practice medicine in one state may be economically much more valuable than a license in a sister state.² The factors governing this are relative wealth, climate, transportation facilities, hospitals, clinics, medical and other schools, and the presence of certain cultural and recreational advantages.

If a board in one state attempts to overcome the economic shortcomings of that state by lowering the passing grades required for licensure (and many states do just that) in an attempt to secure more physicians for the state, they should be permitted to do so, even though, in the opinion of many of us, this is not a proper

solution to the problem and does, indeed, tend to create various standards of practice in the country. Nevertheless, it is an attempt to solve a problem peculiar to a given segment of the United States.

As a matter of record, many states have not failed an applicant in a licensure examination for ten or fifteen years. If the State of Illinois simply rubber stamped the licenses of these sister states, the time would be reached when all applicants would take their examinations in these states and immediately apply for an Illinois license. The net result would be that the State of Illinois would no longer be setting its own standards but would allow some other state to set such standards. This is a "back-door" method of obtaining a license that is quite familiar to most applicants.

Of the tests for clinical competency, during this two year period, 615 were given with 94 failures, or a rate of 15.2%. The record of each failure was scrutinized very carefully before such was confirmed.

Licensure by Eminence

For many years, it had seemed to members of the Medical Examining Committee, that it was literally stupid to put certain applicants through the routine expected of others. There were many men in medicine, eminent in their fields, that were forced, for legal reasons, to follow the customary examination proceedings. In 1967, a discretionary clause was added to the Act and the Committee adopted criteria for determining eminence. These criteria follow:

1) The applicant must be properly licensed in a jurisdiction recognizing reciprocity with Illinois.

2) He must be appointed to, or have filled, professorial positions in responsible institutions.

3) He should be certified by a recognized national board and must be a member of recognized professional and educational societies.

4) He must have contributed significantly to the literature of medicine as determined by publication in well-recognized periodicals.

5) The entire Medical Examining Committee must unanimously approve the decision.

6) The entire curriculum vitae of the individual must be included in the minutes.

The Myth of Licensure Requirements As a Deterrent to Practice

One hears repeatedly that many qualified men would practice in Illinois if it were not so difficult to procure a license. This view-point, in the opinion of the Committee, is not correct and is not supported by the evidence at hand.

One of the recent studies—that of the Department of Health Manpower of the American Medical Association—was adopted by the House of Delegates at its December, 1969, Clinical Convention in Denver, Colorado.³ After reviewing in some detail the physician population ratios in all of the states the conclusion was reached:

"From this tabulation, the council finds no evidence which would indicate that complete interstate reciprocity would alleviate any current inequitable interstate distribution of physicians in the United States."

A very detailed study appeared in 1967, called "Medical School Alumni."⁴ This traced all living graduates of all medical schools and where they were practicing. For our purpose, the figures between 1960, and 1967, will be used. During this period, the five medical schools in Illinois graduated 4,120 individuals. Of this number, 1,404 (34.0%) were practicing in Illinois in 1967. This occurred despite the fact that almost the entire number of 4,120 individuals was entitled to an Illinois license for the asking by virtue of National Board certification.

A Medical Practice Act Commission of the Illinois Legislature⁵ studied this problem in some depth between 1959 and 1962, and among other things, reached much the same conclusion.

It boils down to the fact that a potential partner or employee will accept the best offer, everything considered, that is made. He may use alleged difficulties in licensure as an excuse to accept an offer in another state, but if careful checks are made, the grass is usually greener in the place of his final choice.

The Fallacy of Many Examinations

The charge has been leveled that Illinois does not examine continuously as other states do. Let us look at the record.

There are only three states that examine four times yearly—Illinois, Nevada and Rhode Island.

There are two states that examine three

times yearly—Connecticut and New Jersey.

There are four states examining once yearly—Alabama, Mississippi, Oklahoma and Washington.

All other states, including the District of Columbia, conduct two examinations a year.

With the advent of the Federation of State Medical Boards' examination (FLEX), almost all of the states, within a few years, will have two examinations a year.

Causes for Delay in Licensure

If the job is to be done correctly, there are many sources of delay that are almost unavoidable.

In reciprocity or licensure by examination, it is necessary for the Department to obtain data directly from the original source; that is, the medical school granting the degree, the hospital to prove internship and residency, the state to prove adequate licensure, and Federation headquarters to verify FLEX grades. It may come as a shock to some individuals that an applicant must be constantly and uniformly checked to prevent fraud.

Another source of delay is National Board certification. As an example, members of the Committee interviewed and checked applications of 62 men during the Illinois State Medical Society meeting in May. The greater part of these had not yet completed internship. Therefore, they were provisionally approved, pending permanent certification after July 1, by the National Board. This means each hospital involved must testify to the successful completion of the internship, the National Board must then notify the individual states (and there are several thousand to process), and since these come trickling in day by day, it is useless to try to process one at a time.

It must be remembered that the Director cannot issue a license without the recommendation of the Medical Examining Committee in writing. Another point is often overlooked; the Director also administers 27 other professions and trades. In addition, he runs the Illinois State Museum, and must control research and publications in geology, zoology, entymology, botany and related fields. He also devotes time to an office in Chicago and one in Springfield.

After the Director's signature is obtained,

the clerical work of turning out licenses begins, and this is no short or easy task.

Conclusion

Licensure to practice medicine is not a simple subject. There are probably different ways of facilitating some of these steps, but it must be emphasized and recommended that proposed changes in the Medical Practice Act be scrutinized very carefully, and in depth, by the Illinois State Medical So-

ciety before suggestions for change are made to the Legislature. ◀

References

1. Resolutions 70M-1 and 70M-2, House of Delegates, *I.M.J.*, 137:430, 1970.
2. Schnepf, K. H., "Problems in Medical Licensure," *J.A.M.A.*, 211:1189, 1970.
3. Proceedings. A.M.A. House of Delegates. Denver, Colorado, December, 1969.
4. Medical School Alumni, 1967, American Medical Association, Chicago, 1968.
5. Shortage of Illinois Physicians in General Practice, Memorandum, Illinois Legislative Council File 4-416, December 1962.



OUR VIOLENT SOCIETY. By David Abrahamson, M.D. Funk & Wagnalls, New York, \$7.95

OUR VIOLENT SOCIETY is a detailed analysis of the causes of violence in the United States today. Written with clarity and expertise, it is a report on why this country is the most violent nation ever to become a world power.

Using actual case histories as examples, Dr. Abrahamson, a distinguished psychiatrist and social analyst, deals with the roots of violence in America—on the individual and the national levels. Separate chapters deal with manifest violence, hidden violence, racial violence, sex and violence, instinctive and learned aggression, Lee Harvey Oswald and other political

assassins, the American Dream, detection of the potentially violent person, and the means to a calmer, healthier society.

OUR VIOLENT SOCIETY is based on Dr. Abrahamson's extensive research in the field of violence and crime, including his work at the Psychiatric Institute of Columbia University, as consultant to the Department of Mental Hygiene for the State of New York, and as a member of the Board of Overseers of the Lemberg Center for the Study of Violence at Brandeis University.

In this book, Dr. Abrahamson coldly evaluates the total pattern of social turbulence in the United States and, perhaps more important, presents reasoned and feasible long-range goals vital to our future existence.

Checklist to Avoid Excess Auto Pollution

Auto emissions account for over 60% of our air pollution. Each year 1,000,000 acres of land are turned into highways, and each year traffic gets heavier, slower, noisier and deadlier.

Reverse this trend and don't drive into the city; use public transportation or better yet, walk or bicycle whenever possible.

If you must drive, you can reduce the amount of pollutants your car releases by:

—making sure your engine does not burn excessive oil

—changing oil and filters at recommended intervals

—replacing faulty carburetors and fuel pump gaskets

—checking your carburetor adjustment periodically

—checking spark gaps and replacing spark plugs regularly

—avoiding excessive idling

—avoiding racing starts

Paul R. Ehrlich :

A biologist's remarks on the "population explosion"

BY MICHAELYN SLOAN/CHICAGO

"A declining death rate" is the key to the problem of over-population confronting us today, according to Paul R. Ehrlich, Stanford University professor of biology, and author of the controversial book, *THE POPULATION BOMB*. (Ballantine Books, Inc., N.Y., \$0.95)

Addressing his remarks at a "teach-out" held in conjunction with the First National Congress on Optimum Population and Environment, in June, in Chicago, Ehrlich briefly outlined how today's over-abundance of people came about, and discussed the possibilities open to curb this problem.

The Past and Present

Ten thousand years ago—approximately 8000 B.C.—in the Western part of Asia, man laid aside his weapons for hunting and picked up the implements necessary for farming. This "agricultural revolution" enabled man to grow his own food and store it, with the result—a decline in the death rate via this newly found form of stability, and the beginning of the "attack" on the ecological life support systems of the Earth.

Three and one-quarter billion people now inhabit the Earth, with an increase of 70 million each year. The ecological attack, begun ten thousand years ago, continues, draining our resources, and in effect, "stealing from our children."

Only recently have Americans learned that many millions of their own fellow citizens go to bed hungry every night, stated

Ehrlich. Mention of the word, "starvation" brought to mind countries such as India, or more recently Biafra.

"The concept of two billion people living on this planet without adequate diets truly staggers the imagination. How can it be that 10-20 million people, mostly children, are starving to death each year while we pay some farmers not to grow food?" Ehrlich stated. He explained this "surplus" food now produced is a surplus in that it is more food than people can afford to *buy*, and not more than they can *eat*.

Environmental Deterioration

In terms of environmental deterioration, Ehrlich outlined the effects of over-population:

- Life expectancy will be shortened.
- Poisons will assault the life supporting systems—e.g. photo-synthesis—that we rely on.
- The haze from agricultural dust is the biggest source of air pollution, with the automobile and industry contributing factors.
- Air pollution is causing the Earth to cool, thereby changing weather conditions, which in turn affect agricultural production.
- A world wide plague—though remote sounding—would result from the equation: more people=more disease. With this excellent transport system—people—natural mutations would occur and

the possibility of animal viruses being transferred to men could come about.

- And finally, with the per capita slice of resources in danger, a thermonuclear war between nations of starving people would occur.

Global Situations

Population control, contrary to public thought, must begin in White America, according to Ehrlich. "Blacks are the victims of the polluting done by White America," he stated. Ehrlich emphasized that "no black individual should have to listen to any whites until the black man can be treated with the full rights accorded white citizens of this society." "People cannot be expected to save a world which shows them no interest," he concluded.

Ehrlich called for an end to racism and war in solving the problem of over-population. Changes must come about in the world organization structure, where men are willing to work beside one another in solving their common problems.

"In the nations that most of us prefer to label with the euphemism 'underdeveloped,' but which might just as accurately be described as 'hungry,' the people will be unable to escape from poverty and misery unless their populations are controlled. With the populations of these nations doubling every 20-30 years, in order to maintain present living standards, in two decades, everything must be duplicated—agricultural production, doctors, homes, imports, etc. It is problematical whether the United States could accomplish a doubling of its facilities in 20 years, and yet the United States has abundant capital, the world's finest industrial base, rich natural resources, excellent communications, and a population virtually 100% literate," Ehrlich states in his book, *POPULATION RESOURCES ENVIRONMENT, ISSUES IN HUMAN ECOLOGY*.

In developed countries, such as the Soviet Union, which ranks second in over-population, and Japan, ranking third, the quality of life is being dramatically overloaded as these countries struggle to maintain affluence and grow more food, which in turn leads to environmental deterioration, notes Ehrlich.

"The air grows more foul and the water more undrinkable each year. Rates of drug usage, crime, and civil disorder rise and

individual liberties are progressively curtailed as governments attempt to maintain order and public health." Ehrlich stated, "But the global polluting activities of the developed countries are even more serious than their internal problems."

He summed up the situation: "The people traveling first-class are, without thinking, demolishing 'Spaceship Earth's' already overstrained life-support systems."

Population Control

"Think of society's population as a whole in planning your family. Quality of our children and not quantity should be the prime objective of today's parents through better diet and more educational opportunities." Ehrlich explained that it would take twenty generations before a genetic trait of high quality would show up in a child.

He noted that pressure must be taken off women to have children, and emphasis must be placed on supplying those they already have with the necessary essentials.

An advocate of male contraception, Ehrlich encouraged vasectomies for men; "Lots of men are trying very hard to keep women from having children through birth control," he stated.

Directing his attack to the medical profession, Ehrlich questioned the quota placed on women admitted to medical schools, in view of the severe shortage of doctors in existence. He also questioned the talent not being tapped in the black population for medical personnel.

Summary

"The next decade will determine man's fate as an evolutionary failure," Ehrlich stated. He offered the following recommendations for a positive approach to the population problem:

- Apply political pressure to induce the United States government to assume its responsibility to halt the growth of the American population.

- De-develop the U.S. by bringing our economic system—particularly our patterns of consumption—into line with the realities of ecology and the world resource situation.

- Once the U.S. has begun its own clean up program, it can turn its attention to the development of other countries. ◀

Groups to Join

Following is a listing of the names and addresses of just a few of the pollution, ecology, population, and conservation groups you might be interested in contacting either to join or to receive information.

Clean Air Co-ordinating Committee
1440 West Washington Boulevard
Chicago, Illinois 60607

CAP—The Campaign Against Pollution
65 East Huron Street
Chicago, Illinois 60611

Great Lakes Chapter of Sierra Club
c/o Mrs. Margaret V. Robuck
1248 West 87th Street
Chicago, Illinois 60620

Illinois Audubon Society
Field Museum of Natural History
Roosevelt Road & Lake Shore Drive
Chicago, Illinois 60605

DuPage Audubon Society
Dr. Russell Mister, President
1006 North President
Wheaton, Illinois 60187

Izaak Walton League of America
1326 Waukegan Road
Glenview, Illinois 60025

Nature Conservancy
1900 Dempster
Evanston, Illinois

John Muir Institute for Environmental Studies
c/o Dick Norgard
5107 S. Blackstone
Chicago, Illinois 60615

Lake County Soil Conservation District
P.O. Box 186
Lake Zurich, Illinois 60047

Open Lands Project
Gunnar Peterson, Director
53 West Jackson Boulevard
Chicago, Illinois 60604

Planned Parenthood Assn.
185 North Wabash
Chicago, Illinois 60601

Zero Population Growth
c/o Mrs. Robert Coburn
6019 South Ingleside Drive
Chicago, Illinois

Zero Population Growth
Northwest Suburban
Mrs. E. Maynard Beal
587 Laurel Street
Elk Grove Village, Illinois 60007

Zero Population Growth
367 State Street
Los Altos, California 94022

Science Info. Speakers' Bureau
Dr. J. Joseph Levin
Chicago Medical School
2020 West Ogden Avenue
Chicago, Illinois

Local Chapters of League of
Women Voters frequently are
active in pollution fight

Friends of the Earth
30 East 42nd Street
New York, New York 10017

Campaign to Check the
Population Explosion
60 East 42nd Street
New York, New York 10017

Forest Preserve District of Cook County
County Building
Chicago, Illinois

Legislators to Write

Following is a listing of members of Congress to whom you can write and tell your concern over the pollution crisis.

House of Representatives

Committee on Agriculture (W. R. Poage, Chairman)
Subcommittee on Forests (John L. McMillan, Chairman)
Committee on Appropriations (George H. Mahon, Chairman)
Subcommittee on Interior and Related Agencies (Julia Butler Hansen, Chairman)
Subcommittee on Public Works (Michael J. Kirwan, Chairman)
Committee on Government Operations (William L. Dawson, Chairman)
Subcommittee on Conservation and Natural Resources (Henry Reuss, Chairman)
Committee on Interior and Insular Affairs (Wayne N. Aspinall, Chairman)
Subcommittee on National Parks and Recreation (Roy A. Taylor, Chairman)

Senate

Committee on Agriculture and Forestry (Allen J. Ellender, Chairman)
Subcommittee on Soil Conservation and Forestry (James O. Eastland, Chairman)
Committee on Appropriations (Richard B. Russell, Chairman)
Subcommittee on Department of the Interior and Related Agencies (Alan Bible, Chairman)
Subcommittee on Public Works (Allen J. Ellender, Chairman)
Committee of Commerce (Warren G. Magnuson, Chairman)
Subcommittee on Energy, Natural Resources and the Environment (Philip A. Hart, Chairman)
Committee of Interior and Insular Affairs (Henry M. Jackson, Chairman)

Subcommittee on Public Lands (Walter S. Baring, Chairman)
Committee on Merchant Marine and Fisheries (Edward A. Gormatz, Chairman)
Subcommittee on Fisheries and Wildlife Conservation (John D. Dingell, Chairman)
Committee on Public Works (George H. Fallen, Chairman)
Subcommittee on Rivers and Harbors (John A. Blatnik, Chairman)
Subcommittee on Roads (John C. Kolucznski, Chairman)

Subcommittee of Parks and Recreation (Alan Bible, Chairman)
Committee on Public Works (Jennings Randolph, Chairman)
Subcommittee of Air and Water Pollution (Edmund S. Muskie, Chairman)
Subcommittee on Flood Control—Rivers and Harbors (Stephen M. Young, Chairman)
Subcommittee on Public Roads (Jennings Randolph, Chairman)

Support anti-pollution bond issue Nov. 3

Governor Richard B. Ogilvie has asked for ISMS' support on the \$750 million anti-pollution bond issue on the ballot November 3.

The bond will enable the state to pay 25% of the cost of constructing or improving more than 400 municipal and sanitary district sewage plants already planned and authorized, which are vital for cleaning up the streams, rivers and lakes of Illinois.

Illinois needs sewage treatment improvements costing \$2.2 billion over the next 10 years to comply with standards established under the federal Water Quality Act of 1965.

A 25% state contribution would also open the way for increasing any federal grant from a 30% share to a 50-55% one.

Illinois is one of the few major industrial states which presently offers no state assistance to local government for pollution

control.

Currently pending are 488 projects downstate, plus various others serving eight drainage basins in the Chicago Sanitary District. These projects will enable Illinois to comply fully with the water quality standards established under the federal Water Quality Act.

Presently 90% of the mileage of the Calumet River fails to meet those standards; 80% of the Illinois River; and 40% of the Rock River. It is estimated that sewage causes approximately 70% of the pollution problem in streams and lakes, compared to 30% contributed by industry.

A bond issue is needed because comprehensive long-range planning cannot rely on annual appropriations from the legislature. The bond issue will not require any new taxes, since the bonds will be paid off from general state revenues.

Professionals vs Communities

The health professionals still meet this kind of problem, but now they also are confronted with the other extreme. Some communities are unhappy at the rate of progress which has been achieved by professionals. They see a great deal of action, but very little progress. This is especially true in the inner city. They see a large amount of money being spent on programs, but they do not see enough understanding of people. They are tired of the indignities which they receive from health professionals. The difference now, however, is that they are not willing to take this passively. Some segments of the community are angry and today the professional will be reduced to impotence, not because he is alone, but more likely because the community has demanded full control. (M. Alfred Haynes: *Professionals And The Community Confront Change*, *Am. J. of Public Health* 60:3 [March] 1970, pages 519-523.)



THE DOCTOR'S LIBRARY

SURGERY ANNUAL (Volume 1) By Philip Cooper, M.D., editor, Appleton-Century-Crofts, New York, 1969.

The 1969 **SURGERY ANNUAL** was conceived as a current review of recent advances or modifications in practical surgical management and in the basic sciences as related to surgery. The chapter headings cover a wide variety of subjects of interest to students and house staff. All of the bibliographies are current and as such will be a helpful starting point for the surgeon in search of answers to specific problems.

Topics of general interest covered include physiologic monitoring and care of seriously ill surgical patients, cardiopulmonary resuscitation, shock, antibiotics, gastric physiology and cancer chemotherapy. Both practical and theoretical advances are surveyed. Transplantation and organ preservation are also included in the chapters of special interest. These topics are presented extremely well. Orthopedic surgery is included, with such topics as arthrography, radioactive tracer examinations of bone, new concepts of limb amputation and musculoskeletal injuries. There are chapters on cardiac surgery and neurosurgery also.

Perhaps the major failing of the **SURGERY ANNUAL** of 1969 is the lack of in-depth coverage of many of the topics included, while the major strength is the fact that the material is all current and up to date.

Julius Conn, Jr., M.D.

A GUIDE TO DERMATOHISTOPATHOLOGY. By Hermann Pinkus, M.D., M.S. and Amir H. Mehregan, M.D. 546 pages. Appleton-Century-Crofts, Educational Division, Meredith Corporation, New York, New York, 1969. Price \$20.00. 403 illustrations.

This book as pointed out by the authors is intended to guide the students and residents in dermatology and pathology in

their study of diseases of the skin.

The book is divided into seven sections entitled: General Part, Superficial Inflammatory Processes, Deep Inflammatory Processes, Granulomatous Inflammation and Proliferation, Metabolic and Other Non-inflammatory Dermal Diseases, Non-neoplastic Epithelial and Pigmentary Disorders and Malformation and Neoplasia.

It is an orderly and systematic presentation of the subject starting with pitfalls and artifacts produced by histologic technique or in the course of biopsy. Then normal skin histology is reviewed through the liberal use of diagrams and microphotographs before going into the various disease entities.

In contrast to the standard textbooks on the skin, the authors have concentrated on enumerating the histologic findings which in their own experience aid in making the diagnosis, rather than including clinical descriptions of the lesions. Moreover, the authors admit that the bibliography is limited mainly to most of their publications except where indicated, since the views expressed are their own. The illustrations are very clear and well-chosen.

The book is of definite value to the students and residents in both Dermatology and Pathology.

Paul B. Putong, M.D.

DISEASES OF THE CHEST (3rd Edition). By H. Corwin Hinshaw, 799 pages, illustrated, Philadelphia, London and Toronto, W. B. Saunders Co., 1969.

The third edition of **DISEASES OF THE CHEST** by Hinshaw continues to be a well written and comprehensive textbook on medical chest diseases. Moreover, the major surgical indications in diagnosis and treatment are adequately presented.

The excellent organization of the subject matter is welcome in that many of the

common defects of a multiauthored text have been avoided. The presentation of the various subjects is unified, and the space allotted for each is commensurate with its importance in the practice of medicine. The references are limited in number, but in most instances key articles have been chosen for further reading so desired.

One of the outstanding features of the third edition is the quality of the chest roentgenograms and other illustrative material throughout the text. The chest roentgenograms are among the best the reviewer has seen in any textbook. The publisher is

to be commended on the exceedingly clear and beautiful reproductions of these roentgenograms.

The text material is presented on a practical level throughout. The chapters on "Clinical Evaluation of Radiologic Examinations" and "Segmental Anatomy of the Tracheobronchial Tree and Lungs" will be of benefit to anyone who reads them.

This text may be highly recommended for the student, house officer and nonspecialist. Surgeons also will find this text to be a worthwhile review of the general subject of chest disease.

Thomas W. Shields, M.D.



Growth is a beautiful word

BY LESLIE LEE/CHICAGO

The Illinois Medical Assistants Association is proud of the many new chapters being formed in our state to help broaden the educational horizons for your Medical Assistant.

Through outstanding speakers, films and dramatizations each county society brings to its members the unique opportunity of learning experiences, emphasizing some facet of its work. We are a non-profit organization promoting the practice of good human relations between doctor, patient and medical assistant. Our American Association of Medical Assistants membership in our 15th year encompasses approximate-

ly 15,000 members throughout the fifty states.

Our goals are to maintain and advance standards of professional employment among Medical Assistants and to render loyal and efficient service to the medical profession and to the public.

Membership is open to persons employed six months or longer. If your Medical Assistant is not a member, now is the time to consider the many advantages. Both you, Doctor, and your Medical Assistant will benefit from your Association. Please contact Mrs. Norma Domanic, 150 Ash Street, New Lenox, Ill. 60451 or Mrs. Vivian Kraft, RR #2, Normal, Illinois 61761.

Sign of the Times

"NEW YORK—(UPI)—The company's (NBC) latest offer of a \$50-a-week salary increase and shorter work weeks was rejected. . . . The \$50 wage increase would have made NBC technicians the highest paid among the three major networks."

—Washington Star, May 1.

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SOCIO ECONOMIC *news*

A service of the Public Relations and Economics Division

By JOSEPH J. LOTHARIUS

Will MDs Become Hospital Employees?

Plans for hospital-based pre-paid, closed panel group practice programs are being discussed by medical staffs in more than a dozen Illinois hospitals. A study prepared by one of the hospitals calls the establishment of such a group plan necessary for its very survival. Several down-state hospitals think that 8 to 12 physicians are required to make a group practice feasible. Still to be determined in most of the studies currently being done is:

- What are the financial benefits to the hospital?
- How does the physician get paid?
- What type of relationship would exist between hospital and doctor (would it be an employer-employee relationship)?
- Would an insurance carrier be sought to underwrite such a prepaid plan?
- Who would perform the claims processing?
- Finally, how would an AMA policy relating to MD-hospital relationship be interpreted?

The policy reads "A physician should not dispose of his professional attainments or services to any hospital, corporation or lay body by whatever name called or however organized under terms or conditions which permit the sale of the services of that physician by such agency for a fee."

+++++

How Will Your Practice Be Affected?

How will your practice be affected by new innovations in health care delivery? Find out by attending the ISMS Leadership Conference to be held at the Continental Plaza hotel in Chicago on Sunday, November 15. Prominent speakers will discuss the major proposals for health care delivery and bring these concepts into sharp focus for ISMS members. The Conference will explore the physician's role in: Foundations for Medical Care; Health Maintenance Organizations; and hospital-based group practice programs. Watch for further details in the next few weeks and reserve the date—NOVEMBER 15—now!

+++++

ISMS Board Recognizes Foundation Concept

ISMS Trustees approved a recommendation to recognize Foundations for Medical Care as another system for health care delivery in Illinois. The Board's new Committee on

Health Care Financing will study the Foundation concept to determine the feasibility of implementing such a program by the Medical Society. The Committee will also consider pre-paid hospital based group practice plans presently being discussed by many physicians throughout Illinois.

Consumer Drug Costs Declining

Significant facts recently released by the Pharmaceutical Manufacturers' Association (PMA) reveal that the average retail cost of a prescription is \$3.68, 75% are priced at less than \$4.50; consumer costs for prescription drug products are declining as a share of the total medical care dollar; pharmaceutical manufacturers will spend an estimated \$600 million for research and development during 1970; the national output of the U.S. has been expanded over \$7 billion in a single year as a result of improved medical treatment and new medicines for just four major diseases.

The PMA is a non-profit trade association comprised of some 120 companies producing 95% of the nation's prescription drugs.

A Study of Health Care In the '70s

An HEW grant of \$727,000 has been awarded to the Center for Health Administration Studies (CHAS) of the University of Chicago's Graduate School of Business. The grant will finance a survey analyzing the medical experience of the American people in 1970—their use of health services, the cost of these services, and methods for payment for them. Among other findings, the survey will disclose the impact of Medicare and Medicaid on the nation's health and its medical delivery system. CHAS expects the study will take three years to complete. A preliminary report is expected in July, 1971.

Health Care

Those physicians who tend to look upon the Medicare law as the turning point, in public policy regarding health, are merely viewing a small arc of the wide circle of events, which already have been and are yet to be generated as a consequence of this legislation, which passed virtually unnoticed and unheralded in the plethora of health legislation of the '60s.

The Comprehensive Health Planning and Public Health Service Amendments of 1966, did indeed formulate the principles for the design of a framework around which new directions and courses of action would be developed for the health care of the American public. But, more, it introduced new concepts and structures which would assure the broadest voluntary involvement of Community forces and institutions in its implementation. If there are any doubts regarding the intent of Congress, a single sentence in the preamble to the law should dispel them. It reads:

"The Congress declares that fulfillment of our national purpose depends on promoting and assuring the highest level of health attainable for every person, in an environment which contributes positively to healthful individual and family living." (Malcolm C. Todd.: *The Physician and Comprehensive Health Planning*. *California Med.* [Apr.] 1970. 112:68-70.)

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NEW TOOL FOR SOCIAL CHANGE

Medical center complexes may lead to more subtle changes in the practice of medicine than most physicians realize. There is little doubt that they will provide medical care for more people with greater efficiency. But to do this, "hospital privileges" as now practiced will be largely a thing of the past. Medical teams will provide community care and someone at the top will dictate what services a physician is most capable of providing. Doctor X may be told to run the renal dialysis, Y to deliver the babies, and Z to run the emergency room at night. The big question is, "who will tell whom what to do?"

Neighborhood health centers are outside medical center complexes. They could become the vehicles leading to social and medical change. These centers were started initially in response to community discontent and the demands for popular participation in, and control over, the formation of social policy. According to Dr. Eugene Feingold, a political scientist, the University of Michigan School of Public Health, the government, in establishing local health centers, emphasized that its role would involve participation rather than control. But the power struggles among members of the center and between the center and the community has the potential for changing established relationships.

Black physicians working in the ghetto

have long served the poor without cost or at low fees. Now that the poor are able to pay for care through Medicaid, these physicians feel they should be paid for their services. In some areas the centers have been forced to operate with a staff of black physicians drawn from the ghetto. The majority are able to participate only on a part-time basis.

The neighborhood health center not only offers medical care but exerts economic power as employer, bank depositor, and purchaser of goods and services. Some centers also oppose any attempt on the part of the local pharmacists and medical societies to exercise local and national political influence to restrict their programs.

Participation at the community level has created some conflicts. Whenever the center serves a mixed community the struggle for power and rewards is ethnically based. Power struggles between members of the health team also result in disagreements. But Dr. Feingold believes the neighborhood health centers may change the individual by providing power to the powerless and help to make authority legitimate once more.

T. R. Van Dellen, M.D.

Reference

"Health Centers as Vehicles Leading to Social Change," *Public Health Reports* (Apr.) 1970, page 285.

"Cocked Shotgun" On Highways

"Raw defiance of law and momentary demonstrations of manhood with a car are like walking into a crowd with a cocked shotgun. You don't intend to kill anyone, and getting yourself messed up is not at all what you had in mind. But it's a cinch you'll be a loser and so, tragically, will be friends and total strangers. Totally innocent friends and strangers."

The above paragraph is quoted from the latest edition of the annual booklet of highway accident statistics from The Travelers Insurance Companies.

This "cocked shotgun" went off on America's highways many times in 1969. The annual survey of motor vehicle accidents shows that such mishaps last year claimed more than 56,500 lives and injured

another 4,700,000 men, women and children.

The "cocked shotgun" was the driver going too fast for highway conditions, the rash and carefree youth, the driver passing on curve or hill, who didn't signal.

Excessive speed continued to be the Number One Killer, accounting for more than 18,700 deaths and 1,056,000 injuries. Thoughtless driving, even at moderate speed, accounted for 5,500 deaths—and the greatest number of injuries (1,267,000).

Pedestrians too, died in great numbers in 1969. Crossing between intersections claimed 4,040 lives and injured more than 67,800 persons.

To end this carnage on our highways, everyone driving or walking must make safety his business. X.

Artificial Lung to be Developed

A grant of \$34,753 has been awarded to Marquette School of Medicine by the John A. Hartford Foundation, Inc., New York City, for development of a new type of artificial lung. Announcement of the one year research award was made jointly by Ralph W. Burger, foundation president, and Dr. Gerald A. Kerrigan, dean of the medical school.

Small models of the lung have been tested by Dr. Richard D. Stewart, associate professor and chairman of the Marquette department of environmental medicine, and Edward D. Baretta, research engineer in environmental medicine. The two men have been named as co-investigators under the grant.

The lung has been tried with success in the laboratory for periods up to 26 hours. The Hartford foundation grant will permit construction of a clinical size unit, intended first for laboratory tests. When development reaches the stage of human trial, the larger model is expected to assist or even take over pulmonary function for patients with both acute chronic lung disease, such as hyaline membrane disease of the newborn, pneumonia, and possibly emphysema. Another application would be to take over lung function during surgery.

The new model will be a small device scaled to the size of a half-gallon cylinder encasing thousands of fine silicone rubber

tubes. The tubes are approximately the size of darning thread. Blood flowing through the tubes receives oxygen through semi-permeable walls. In similar fashion, carbon dioxide passes out of the blood and is carried away via an oxygen bath flowing around the tubes. The silicone material used to construct the tubes is the best known man-made material for gaseous exchange.

The first laboratory tests were done in January and February of this year. In these tests the lung proved its ability to supply measured amounts of oxygen to the blood and to remove waste carbon dioxide. The amount of oxygen received via the normal respiratory route was controlled to various levels with the oxygen deficit made up by the artificial lung. The lung functioned well during the several test runs, the longest being 26 hours. There was no significant damage to the blood such as occurs with other oxygenators.

The clinical model will be designed to feed oxygen into the blood stream and to remove carbon dioxide, both in amounts sufficient to sustain human life. Another feature of the lung will be the small amount of blood needed to "prime" the unit in order to get flow started through it. Approximately one cup will be required for "priming" the clinical model. Other oxygenators require several times more than this amount.

The Exceptional Parent Magazine Due For Release

The Exceptional Parent, a new magazine, by the Psy-Ed Corporation, will be ready for distribution in September. The magazine, unique among educational and professional publications, will aim "to provide practical help for the parents of children with disabilities." It will combine the knowledge of experts with the day-to-day experiences of laymen. The magazine will deal with many issues that affect the exceptional child and will cover such topics as the role of the family, the nature and role of the various professional groups with whom the family is apt to come in contact, and the ways in which certain aids can be helpful. Information will be easily understandable, practical as well as theoretical. The magazine will also provide a medium through which parents can exchange ideas, share concerns, and discover new approaches to common problems.

The founders and editors of **The Exceptional Parent** are three professional colleagues who are practicing psychologists and university professors: Lewis Klebanoff, Stanley Klein and Maxwell Schleifer.

Charter subscriptions to **The Exceptional Parent**, which will have national distribution, are \$6.00 a year. Further information may be obtained by writing **The Exceptional Parent**, Box 45, Newtonville, Mass. 02160.

Amniotic Fluid Studied In Prenatal Situations

A method of direct chemical analysis has been developed at The University of Chicago to detect diseases that cause physical and mental abnormalities in an unborn baby up to six months before its birth.

This advance diagnosis can allow the physicians and parents of abnormal children to seek termination of pregnancy while such a procedure is still simple and safe or to assure parents with potential genetic problems of their child's normality.

The technique was developed by Dr. Reuben Matalon and Dr. Albert Dorfman of The Pritzker School of Medicine.

"The technique involves inserting a needle into the uterus and withdrawing a sample of the amniotic fluid which surrounds and protects the unborn baby," Dr. Dorfman said.

"This fluid can then be analyzed for the amount and composition of a group of chemical compounds (mucopolysaccharides). The presence of these substances in

abnormal amounts or in abnormal forms indicates that the unborn child has a disease of the connective tissues (mucopolysaccharidoses or Hurler's syndrome). This disease causes severe mental retardation and crippling.

Previously, amniotic fluid has been used as a source for cells from the unborn child. These cells were cultured, or grown, and then examined visually or chemically to detect cellular abnormalities that may indicate chromosome defects, that occur in mongolism, or chemical defects that occur in inherited diseases.

"In the past, all such a couple could do was to either take their chances with the probability factors or refrain from having children. Such couples can now get a definitive diagnosis of their child's normalcy while they still have the option to end the pregnancy safely," Dr. Dorfman said. "This enables them to avoid bearing deformed children and yet have as many normal children as they choose."

The negative power of anxiety...

**This man thinks he may
never work again.**



The patient who has had a myocardial infarction is usually advised by his physician to avoid emotional excitement. All too often his family, acutely concerned, transmits its anxiety to him, urging him to "rest, rest."

How anxiety may interfere

In a study of 336 males who had suffered at least one myocardial infarction, Sigler¹ reports that manual workers showed the lowest percentage of patients returning to work, compared to clerical workers, business and professional men. The author notes that in many cases the mere apprehension that return to work would shorten life prevents the patient from resuming activities." It is also well known that emotional disturbance is probably the most common cause of cardiac disability in postinfarction cases.¹

The anxiety factor in both *coronary* and *precoronary* patients has recently been discussed by Thomas,² who suggests: "Intensive investigation of the sources and kinds of anxiety, and how destructive forms of anxiety can be identified and relieved may be the next important step in the prevention of coronary heart disease."

Relief of anxiety with Librium® (chlordiazepoxide HCl) often proves a valuable adjunct to medical counsel, reassurance and the total management program; may help prevent the postcoronary patient from regressing into a state of invalidism.

As an adjunct in cardiovascular therapy, Librium® (chlordiazepoxide HCl): Quickly alleviates anxiety of mild to severe degree in most cases. Helps expedite cooperation in therapeutic regimen. May be used concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, antihypertensive agents

and diuretics. By relieving anxiety, helps encourage productive activities. Has a wide margin of safety and, in proper maintenance dosage, seldom impairs mental acuity or ability to function. Often effective in extended therapy, usually without diminution of effect or need for increase in dosage—in protracted use, periodic blood counts and liver function tests are advisable.

References: 1. Sigler, L. H.: *Geriatrics*, 22:(9) 97, 1967. 2. Thomas, C. B.: *Johns Hopkins Med. J.*, 122:69, 1968.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

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Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating

drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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First Artificial Lysosomes Open New Scientific Frontiers

A major biological breakthrough has been achieved in the formation of the first man-made lysosomes—so called "suicide sacs" that trigger the inflammatory process and set the state for painful and crippling diseases such as arthritis and rheumatism.

Drs. Gerald Weissmann and Grazia Sessa, New York University School of Medicine scientists, believe they have found a key to the understanding of this process in the "manufacture" of the first artificial organelle—a part of the cell. The artificial lysosome, according to Dr. Weissman, is perhaps the simplest form of organelle.

Dr. Weissmann reported the achievement to colleagues at the Third Annual Symposium of the International Inflammation Club, Brook Lodge, sponsored by The Upjohn Company. The investigator told interviewers that the laboratory-produced organelle, capable of containing and releasing enzymes, behaves in a test-tube environment exactly as its natural counterpart, the lysosome, does in the human body.

Lysosomes are present in most living cells. They contain powerful enzymes which usually are protective, but can become dangerously destructive. When the host cell is attacked by a virus or other foreign particle, the invader is met by the lysosome, engulfed, and destroyed by the enzymes. This process, phagocytosis, protects the body against disease. When the cell is overwhelmed by undigestible mat-

ter, injury, or violent infection, however, the lysosome releases its enzymes into surrounding tissues by mechanisms which are not yet understood. The enzymes proceed to destroy other cells and affect extracellular materials, causing the pain, swelling, and other effects of inflammation.

The artificial lysosome—called a liposome—is structured of fatty substances, or lipids, and formed in thin layers similar to an onion skin. The enzyme—in this case, lysozyme—is captured in the watery inter-spaces between those layers.

The significance of this development, Dr. Weissmann said, is that it permits extensive *in vitro* study of the chemical effects of drugs and hormones on lysosome activity, and particularly, that it will enable research leading to control of the mechanisms by which the lysosome acts—either to protect or destroy its environment.

"The artificial lysosome—the liposome—is made with commercially available purified lipids and enzymes," Dr. Weissmann pointed out. "This means it can be reproduced in any laboratory in the world."

Dr. Weissmann said he now is working on capturing other enzymes within the artificial organelle and that "a logical development of these experiments could be the formation of artificial red blood cells."

Details of the experiments leading to the development of the artificial lysosome was published in the July 10, issue of *The Journal of Biological Chemistry*.

Give Nurses Responsibility

But there is now too much for us to do alone, and we must learn to delegate some of our responsibilities. Nevertheless, we oppose this with countless rationalizations. We think we will lose power or prestige, so we say that change will "weaken the doctor-patient relationship." We refuse to let nurses take patient histories "because the history is the most important part of the examination;" but then we depend heavily on nurses' notes in the hospital, never acknowledging to ourselves how much their observations (history and physical-examination findings) contribute to patient care. In coronary-care units, where it suits our convenience and where patients are seriously ill, we give nurses tremendous responsibility; but we resist giving them one-tenth that responsibility in our office practice, where they could help many more patients. (Len Hughes Andrus, M.D.: *The Enemy Is Us, Medical Opinion & Review* [Apr.] 1970, pg. 30.)

Let's reciprocate

(Continued from page 240)

Let me emphasize that Rock Island County shares the goal of the medical profession in Illinois, including the Illinois Medical Examining Committee—quality medical care for Illinois residents. When a physician wants to come to an Illinois community and is given encouragement by physicians in that community, but provisions of the state law discourage him, it is a blow to the medical profession and also to the community which has been denied that physician.

The Reference Committee hearing made it clear that the Illinois Medical Examining Committee has very broad responsibilities, and it is commendable and laudable that the Committee has been able to do all the law requires it to do. The resolution of those seeking to establish true reciprocal licensing is in no manner or form an attack on the Committee; it is a dedicated and sincere attempt to change the outdated system which requires the Committee to operate as it does.

Medical licensing laws and examinations were established in the days when mail order medical schools were in vogue and an examination was in fact necessary to establish a man's qualifications. Most were amended through the years, but some of the laws have not kept pace with contemporary times. Certainly, under educational standards of the last 20 years, it would seem reasonable to grant a reciprocal license to any qualified physician who is a graduate of any fully accredited medical school in the United States and Canada, who has completed an internship program approved by the AMA and has been duly licensed by a state or is a Diplomate of the National Board of Medical Examiners.

Even those criteria are changing with the internship requirement no longer necessary in some specialty areas. Certainly licensing laws must be changed to keep pace.

We are told that if reciprocal licensing examinations are eliminated for physicians, they must also be eliminated for chiropractors, whose representative on the Illinois Medical Examining Committee would surely cry discrimination. The law discriminates now in that physicians are given one type of examination while chiropractors

are given another. The law also discriminates between physicians who passed the National Board Examination prior to January 1, 1964, and those who passed the same examination after January 1, 1964. The law then should certainly be able to discriminate between physician graduates of schools which are examined and accredited by educational organizations and governmental bodies to assure their educational quality, and chiropractic graduates of institutions which are accredited by only their own trade associations.

If the above reason is valid, it would seem that chiropractic is partially to blame for the physician shortage in Illinois because fear of chiropractic prevents reciprocal licensing without examination. It would also seem desirable and necessary for the appropriate ISMS committee to work on separating medical licensure from chiropractic licensure.

The inclusion of chiropractors under the Illinois Medical Practice Act is a sin of commission which should be rectified at the earliest opportunity. If quality health care is really what we are after, then chiropractic should be outlawed in Illinois, because chiropractors are not trained to diagnose nor to treat disease. Their inclusion in the Medical Practice Act gives chiropractic a stature it does not deserve and demeans the stature of the medical profession.

At the Reference Committee hearing we were told that "if a doctor wants to practice badly enough in a certain place, he'll get there regardless of what the requirements are." This is probably true of the men who go to the most desirable states—California, Florida and Arizona. But let us acknowledge that Illinois does not have the physical attraction of these states, and we must compete with them for practicing physicians and for recent graduates. Let us remember that we are not talking about those physicians who know where they are going to go, but rather about those physicians who are not so sure and whom we are trying to recruit to come to Illinois because there is a chance that we can get them here. If our climate were similar to the above-named states, our job would be easier.

Also cited is a report of the AMA Department of Health Manpower, adopted at

the December, 1969 Clinical Convention. The report tabulated the physician/population ratio of 13 states and their reciprocal agreements, and concluded that interstate reciprocity has no effect on the current inequitable distribution of physicians in the United States. This must also imply that interstate reciprocity has no effect on recruiting. The action of the 1970 ISMS House of Delegates shows that there are many counties in Illinois who do not agree with this premise. The Executive Committee of the Rock Island County Medical Society expressed extreme disgust with this report, stating that it is one thing to sit in an office and tabulate figures, but it is another to get out as a practicing physician and actively recruit. While it may not alter nationwide distribution of physicians, those of us who have been actively recruiting know from first-hand experience that lack of reciprocal licensing is a stumbling block.

According to AMA statistics (*JAMA*, June 15, 1970), Illinois ranks fifth behind California, New York, Pennsylvania, and Massachusetts in the number of reciprocity licenses processed annually. New York and Pennsylvania issue licenses by reciprocity or endorsement on a continuous basis; California issues on a weekly basis; Massachusetts issues weekly except during the month of August. Yet Illinois continues to issue them only on a quarterly basis. The resolution passed by the ISMS House of Delegates was intended to eliminate the long delays which often occur in processing and cause the applicant to locate his practice elsewhere.

The Reference Committee report said the major problem is really lack of communication between the licensure applicants and the Medical Examining Committee. While this may occur occasionally, information supplied by the Department of Registration and Education is specific and it seems inconceivable that this could be a major cause of delay. Perhaps the problem is in the Department of Registration and Education and/or its communication with the Medical Examining Committee.

A voluminous report prepared for the Illinois Board of Higher Education in June, 1968, gives a detailed and documented account of current and projected health

care needs in the state. The report points out that one-third of the population sought physicians' services at least once a year 30 years ago; today, two-thirds do so, and the percentage will continue to increase as affluence, education of the population, and private and government-financed insurance programs increase. The report states that 20-25% of the Illinois population has no preventive medical care.

The critical need for physicians is a problem which must be attacked on many fronts. We are firmly convinced that reciprocal licensing would be a great step forward in helping to recruit physicians.

The Illinois Medical Examining Committee is to be commended for the work it has done under a difficult situation, but the situation should be corrected. We wholeheartedly agree with the editorial opinion expressed by Dr. Frederick T. Merchant in the June 15, issue of *JAMA*.

"While it would seem justifiable to give a broad-based examination to the very recent graduate, it has become increasingly clear that this indeed is a disservice to the older and more remote graduate who has confined himself in a specialty area and cannot qualify with any assurance for licensure under the usual procedures," Dr. Merchant said.

Speaking of the need for change, his editorial says: "Unfortunately fixed statutory provisions, under which (medical examining) boards must operate, are too often unduly restrictive or inelastic, even too obsolete, to allow medical boards to meet and resolve the challenges of the changing times in any expeditious or realistic manner. It is paradoxical that state legislatures which seem bent at all costs to develop new medical schools and to express concern over medical manpower and health care, are at the same time obdurate or obstructive at approving changes or amendments in medical practice acts which are corollary to such expansion."

The time for change is here!

We believe that medical licensure and chiropractic licensure must be divorced; that the Medical Examining Committee's activities should be restricted only to licensure of physicians and supervision of already-licensed physicians; that the committee should be given sufficient economic

(Continued on page 280)

Looking for a Place to Practice? Placement Service Lists Openings

In an effort to reduce the number of towns in Illinois needing practicing physicians, the *Journal* is publishing synopses submitted to the Physicians Placement Service concerning openings for doctors.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the placement service.

Information and comments are also requested from physicians living near the communities listed as to the real need and the ability of the town to support additional physicians.

Inquiries and comments should be directed to Mrs. Robert Swanson, Secretary, Physicians Placement Service, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601.

Subsequent to the listings over the past 30 months, the following supplemental list of openings is furnished. This will be continued next month.

BUREAU COUNTY: Princeton; population: 6500. Trade area: 10,000. Opening with two physicians or solo. Eight doctors here including 4 G.P.s. One hundred and thirty bed hospital. Small industry and agriculture. Protestant and Catholic churches. Public and parochial schools. Country club with golf course. Sixty miles from Peoria. New office ready and waiting. Week-end, holiday and vacation relief call. For further information contact: G. E. Rathbun, M.D., 730 S. Main, Princeton.

COOK COUNTY: Chicago. Opening for associate medical director of large manufacturing co. Prefer general practitioner, internist or surgeon. For further information contact: Carl Von Ammon, Boyden

Associates, 111 W. Monroe, Chicago 60603. Phone: 312-782-1581.

COOK COUNTY: Chicago. Field Clinic. Forty-five man group established in 1941; largest private medical clinic in Cook County. Opening for GP or internist. All specialties represented in group. Salary: \$24,000. for GP; \$26,000 for internist. Opportunity for partnership after two years. Nearby Ravenswood hospital expanding to 500 beds in 1971, one block from clinic. For further information contact: Kenneth Hatfield, M.D., 4600 N. Ravenswood Ave., Chicago. Phone: 312-275-7700.

COOK COUNTY: Chicago. Opening for an associate, GP or internist. Open immediately. Financial arrangement negotiable. Doctor owns building with pharmacy, dentist and optometrist as tenants. Near Mt. Sinai and Evangelical hospitals. For further information contact: Marvin Lerner, M.D., 4900 S. Archer Ave., Chicago. Phone: 312-581-7056.

DUPAGE COUNTY: Warrenville; population: 5,000. Opening for GP or internist. Three nearby hospitals. Per cent or salary. Thirty miles west of Chicago. For further information contact: Robert Allison, M.D., Warrenville. Phone: 312-393-1221 or 312-365-6364.

EFFINGHAM COUNTY: Effingham; population: 11,000. Trade area: 60,000. Nine physicians. St. Anthony hospital; 64 beds. Seventy miles from Champaign & Terre Haute, 100 miles from St. Louis. Four drug stores. Agriculture and industry. Fifteen Protestant and Catholic churches. Six grade schools and two high schools. Three golf courses, 2 indoor pools. Lake, etc. Office space available. For further information contact: David Lustig, 111 W. Jefferson, Effingham. Phone: 217-342-2877.

Now Is It a "Slave Labor Law"?

Would you believe that workers file more unfair practice charges against unions than do employers? NLRB reports that during the last quarter of 1969, such charges were filed by 860 individuals and 728 employers and employer associations.

(Continued from page 208)

ommended that ECFMG physicians be granted permanent but limited licenses to practice in the State of Illinois hospitals.

The Board reviewed this matter and referred it to the Committee on Licensure in consultation with the Council on Legislation, for recommendation.

Possible Implementation of Prepayment Plan

The Board received the outline of a possible prepayment plan at the University of Illinois Hospitals in conjunction with IDPA. Payments would be on a capitation basis rather than fee-for-service. The University of Illinois would provide medical services in the so-called valley area on Chicago's west side. This is a demonstration project under Medicaid for a medically deprived area where there is little interference with the private practice of medicine. Patients have the choice of being covered by the plan or of receiving their benefits on the usual fee-for-service basis.

Policy on Release of Hospital Records

The Board concurred with the Policy Committee that the policy regarding release of hospital records should not be changed. This policy states that these records are privileged information and are the property of the patient, maintained in trust by the hospital and are only to be released upon court order. They may be furnished to third party carriers and government agencies in summary or abstract form upon written request by the patient. Statutes may require that records be released to allow benefit payments. However, the Board recognized that ethics and law do not always coincide and the policy should be maintained. The inviolability of confidentiality or records must be protected; however, the Board did recognize that a reasonable request for a summation or explanation of a case should be honored.

Dues Billing Procedure

Upon review of the Finance Committee's report, the Board resolved to include the \$2 House-passed one-time special assessment in 1971, as part of the total dues billing. This will result in a billing for \$107. A notation will be affixed indicating that \$2 is due to the special assessment for sending ISMS publications to SAMA members in Illinois Medical Schools. This procedure will be followed to facilitate automated handling of accounts.

Meetings Scheduled for Board

The schedule for future meeting dates and sites was approved. The October meeting will be at Augustines, Belleville, October 24-25. Other meetings will be:

- Jan. 16-17, 1971 Blackstone Hotel, Chicago
- Mar. 13-14, 1971 Ambassador Hotels, Chicago
- May 15-19, 1971 Arlington Park Towers, Arlington Heights
- July 17-18, 1971 O'Hare Hyatt House, Rosemont

In related actions, the Board:

- heard a report regarding Comprehensive Health Planning activities in Illinois; the Board voted to support retention of this activity in the Department of Public Health rather than in the Governor's Office, as has been proposed; a communication will be forwarded to the Governor's coordinator of health services to make this position known;
- received an indication that the House of Delegates passed a resolution regarding acceptability of the signature of clinic managers on claim forms, rather than requiring physician signatures, is still under study by IDPA;
- referred proposed changes in the Bylaws which would establish affiliate status for specialty societies, to the Committee on Constitution & Bylaws;
- referred to the Task Force on Physician Shortage and Services to Medically Deprived Areas and to the Finance Committee the House resolution requesting the establishment of a loan program for inner-city students, similar to the present Student Loan Program, funds to come from the Task Force allocation;
- instructed the Task Force on Physician Shortage to become a liaison group between ISMS and interns and residents;
- approved dates for the 1970-71, President's Tour, as well as tentative plans for the program format; some new features and extension of hospitality to nurses, hospital personnel and other paramedical groups, will be included in this next tour; sessions on physician's liability will highlight the afternoon sessions;
- received a report from the Policy Committee regarding resolutions 70M-26, changing the function of the House of Delegates to the "state medical forum" and 70M-27, relating to direct House action on ISMS finances; the Policy Committee will report its recommendations directly to the next meeting of the House of Delegates;
- approved the membership, as nominated by the Chairman, of the ISMS Councils and Committees for 1970-71. Upon notification and acceptance of appointments the various groups will be constituted and the full lists will be published in the *IMJ* Reference Issue, October;
- adopted the mid-year budget revision which consisted of shifting some line items to bring them into conformity with actual circumstances and performances; no major revisions were effected and all totals remained the same;
- heard a detailed report on specific programs and accomplishments of the Health Careers Council of Illinois, by its Executive Director Donald Frey; he explained budgets, funding, staffing and related matters;
- authorized staff to explore the feasibility of a state-wide council on homemaker's services, to assist in developing the program and gaining stability;
- heard a report by Dr. Breed on the results of a survey

of students, residents and interns, to determine plans for type and place of practice; the results will be serialized in the *IMJ*;

- reviewed with the AMA Delegation chairman the results of Illinois presented resolutions to the AMA, as well as other concerns of the delegation;
- approved competitive bidding for the *IMJ* and "Pulse" printing, and maintenance of 1970 advertising rates in 1971; in addition heard of possible savings by selective elimination of certain reference issue items; the Board also authorized the Publications Committee to communicate directly with the Committee on Laboratory Services regarding possible advertising by automated laboratories;
- expressed its appreciation and congratulations to Dr. V. P. Siegel for his work on the Council on Legislation and Public Affairs;
- the Board received reports from the officers and trustees for information; no specific actions were called for.

Approvals and Appointments:

Dr. Jack Gibbs, of Canton, was appointed the official ISMS representative to the October 22-24, AMA National Congress on Health Manpower, Chicago;

Dr. J. Ernest Breed will attend the Fourth World Conference on General Practice, August 12-15, Chicago;

The Board recommended for possible appointment to AMA, Committee on Transfusion and Transplantation, Dr. James Hartney of Oak Park and Dr. Louis R. Limarzi, Chicago; Committee on Transfusion and transplantation;

Dr. Harold C. Lueth of Evanston, was recommended for appointment to the AMA Council on National Security;

Dr. Edward W. Cannady of East St. Louis, was named as a member of the Nomination Committee of IRMP;

Dr. William E. Adams of Chicago, was reappointed to the Governing Board of the Midwest Regional Health Science Library;

The AMA Delegation has presented the names of the following physicians to be considered for appointment to the AMA Committee on Long Range Planning and Development: Drs. Philip G. Thomsen, Harlan English, Warren Tuttle and Fredric D. Lake.

Research and training grants accepted by U. of I. at Medical Center

The University of Illinois Medical Center Campus accepted an overall total of \$367,298 in research and training grants for the month of July. Out of 16 grants listed, 6 grants totaling \$226,230 were from the United States Public Health Service.

The funds were allocated as follows: \$25,851, College of Dentistry; and \$341,447, College of Medicine.

The largest single grant, \$60,376, was awarded to Dr. Neena B. Schwartz, professor of physiology College of Medicine, by the United States Public Health Service for the project entitled "Environmental and Hormonal Interplay of Ovulation."

Pollens and molds

(Continued from page 225)

ground fog. Thunderstorms are a particular menace. Favorable conditions occur with unstable air when the weather has been cold with little wind associated with low clouds or smoke at night. Best of all in Milwaukee, is a northeast wind which blows cleaner air from the north over the Great Lakes.

We have previously called attention to the possibility of minimizing the fallout of radioactive particles by means of smoke clouds and by increasing the temperature of a city in order to keep the air unstable. ◀

References

1. Heise, H. A., and Heise, E. R., "Influence of Temperature Variations and Winds Aloft on Distribution of Pollens and Molds in Upper Atmosphere," *J. Allerg.*, 20:378-382, (Sept.), 1949.
2. Heise, H. A., and Heise, E. R., "Distribution of Ragweed Pollen and Alternaria Spores in Upper Atmosphere," *J. Allerg.*, 19:403-407, (Nov.), 1948.
3. Heise, H. A. and Heise, E. R., "Meteorologic Factors in Distribution of Pollens and Molds," *Ann. Allerg.*, 8:641-644 - 681, (Sept.-Oct.), 1950.
4. Heise, H. A., and Heise, E. R., "Effect of a City on the Fall-out of Pollens and Molds," *J.A.M.A.*, 163 (March 9), 1957.

Private hospital

(Continued from page 238)

should be developed to its highest calibre and permit the residents and interns an opportunity to experience and meet an excellent calibre of the teaching. This is particularly relevant in the teaching of foreign interns and residents. The preceptorship system may be applicable, and may be most helpful to the foreign medical graduate initially entering a stateside program.

Summary

The private non-affiliated metropolitan community hospital has a commitment to be an integral part of the local community. Its prime function is to give service. To maintain a high calibre of service, there should be considered the advisability of developing a secondary function of post-graduate medical education. Some of the advantages and disadvantages, solutions and problems, philosophical and pragmatic aspects related to residency and intern training programs have been discussed. ◀

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Down-State Fall Meeting
Champaign-Urbana, Illinois
September 25-26-1970

Friday, September 25

1:00 p.m.—REGISTRATION—Ramada Inn, Champaign, Illinois

3:00 p.m.—SIMULTANEOUS SESSIONS—(1) "General Hospital Psychiatry," Mercy Hospital, Urbana, Illinois

Panel Members: Howard Nelson, M.D., Rudolph Novick, M.D., Harry Little, M.D.

(2) "Childrens' Disorders," Childrens' Research Center, University of Illinois, Urbana, Illinois, Robert Sprague, Ph. D. & Staff

7:00 p.m.—DINNER MEETING—Ramada Inn, Champaign, Illinois, Dinner Speaker: ALBERT J. GLASS, M.D., Director, Illinois Department of Mental Health

Saturday, September 26

9:00 a.m.—THREE SIMULTANEOUS PANELS—at Ramada Inn—Champaign

(1) "Drug Abuse"

John M. Chappel, M.D. et. al.

(2) "Student Mental Health"

Theodore Kiersch, M.D., John E. Kysar, M.D., Robert Chapman, M.D.

(3) "Psycho-Pharmacology—Refresher Course"

Jan Fawcett, M.D.

1:00 p.m.—ILLINOIS-TULANE FOOTBALL GAME
(Tickets for reserved seats to be sold—"first come—first served")

ADDRESS: Dr. Lewis Kurke, Program Committee
Illinois Psychiatric Society
Adolf Meyer Center
Decatur, Illinois 62526

THE VIEW BOX

(Continued from page 223)

Diagnosis: 3. Non-functioning left half of a horseshoe kidney

Horseshoe kidney is the most frequent type of contralateral fusion. It occurs in approximately one in four hundred autopsies and most commonly in the male. In over 90% of cases, fusion occurs at the lower pole. The kidneys tend to ectopic in position, mostly low lumbar or pelvic. The vascular system may arise from unusual sites. The diagnosis is suggestive on the initial IVP in that the visualized portion of the kidney is seen to cross the midline at the level of L₄, indicating that there probably is another portion of a horseshoe kidney which is not visualized on the left. The axis of the right side of the kidney is rotated. The abdominal aortogram reveals an extremely tiny branch of the left renal artery which is displaced around hydronephrotic sacs. The delayed nephrogram demonstrates the crossing of the lower pole of the right side of the kidney and delayed faint filling of hydronephrotic sac. The recognition of this condition is helpful in a proper surgical approach, as the urologist would benefit from the knowledge of the presence of a horseshoe kidney by utilizing an incision which could get him closer to the midline for the separation of the lower pole.

Film Review

"Endoscopic Techniques in Gynecology and Infertility," outlines the use of culdoscopy and laparoscopy procedures in diagnosing and treating gynecological conditions.

The film is available through Wyeth Laboratories sales representatives for showing to physicians in private practice and hospitals, and at medical society meetings. The 27 minute, 16 mm, color film can also be obtained on loan from the Wyeth Film Library, Box 8299, Philadelphia, Pa. 19101.

Veterans who drew compensation for service-connected disabilities rated 50 per cent or more are entitled to additional payments for their dependents, according to the Veterans Administration.

COOK COUNTY Graduate School of Medicine CONTINUING EDUCATION COURSES STARTING DATES—1970

SPECIALTY REVIEW COURSE IN MEDICINE, Part I, Sept. 14 & 21

SPECIALTY REVIEW COURSE IN THORACIC SURGERY, Sept. 21

SPECIALTY REVIEW COURSE IN UROLOGY, Three Days, Oct. 14

SPECIALTY REVIEW COURSE IN OB/GYN, October 19

SPECIALTY REVIEW COURSE IN SURGERY, Part I, October 19

SURGERY OF HEAD AND NECK, One Week, September 21

SURGERY OF STOMACH & DUODENUM, One Week, Sept. 28

MANAGEMENT OF COMMON FRACTURES, One Week, Oct. 26

AMPUTATION SURGERY & REHABILITATION, 2 1/2 Days, Oct. 22

RHEUMATOLOGY, One Week, October 19

VAGINAL APPROACH TO PELVIC SURGERY, One Week, Oct. 5

ADVANCES IN GYNECOLOGY & OBSTETRICS, One Week, Sept. 28

PEDIATRIC SURGERY, One Week, September 28

BASIC ELECTROCARDIOGRAPHY, One Week, October 5

BASIC INTERNAL MEDICINE, One Week, October 12

DERMATOLOGY, One Week, October 5

DIAGNOSTIC RADIOLOGY, One Week, September 21

RADIOISOTOPES, One or Two Weeks, Request Dates

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Information concerning numerous other continuation courses available upon request.

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CO-CHAIRMEN: Jules Masserman, M.D., Mortimer D. Gross, M.D., Albert Glass, M.D.

RESERVATIONS: Actual cost of the Eclectic Conference is \$155 per registrant. The Forest Hospital Foundation and the State of Illinois are underwriting the cost of \$100 per person. Reservations are \$55 per person, including luncheons and cocktail-theatre party. Only the first 125 reservations can be accepted.

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Obituaries

***Arthur K. Baldwin**, Carrollton, died June 26 at the age of 81. He was a member of the ISMS Fifty-Year Club, past president and past secretary of the Greene County Medical Society. He was selected Outstanding General Practitioner of Illinois in 1958.

***Hallard Beard**, Glen Ellyn, died July 25 at the age of 78. He was a member of the ISMS Fifty-Year Club.

***William J. Cassel, Jr.**, Springfield, died July 14 at the age of 51. He was chief of the bureau of chronic illnesses of the Illinois Department of Public Health.

***Chester C. Doherty**, Clay City, died July 22 at the age of 76.

***Joseph S. Drabanski**, Fox River Grove, died August 8 at the age of 63.

Dimitri Gostimirovich, Carbondale, died July 3 at the age of 70. He was chief of laboratory services at the VA hospital in Marion.

Moses A. Jacobson, Waukegan, died August 1 at the age of 74.

***George Koptik, Sr.**, Cicero, died July 25 at the age of 78. He was a member of the ISMS Fifty-Year Club.

***Henry Lescher**, River Forest, died July 31 at the age of 76. He was a member of the ISMS Fifty-Year Club.

***George Panczyszyn**, Glenview, died July 21 at the age of 45. He died while vacationing in Florida.

***William Reilly**, Chicago, died July 4 at the age of 75.

***Umberto Savaglio**, Chicago, died July 27 at the age of 57.

***Otto H. Schulz**, Chicago, died July 1 at the age of 89. He was a member of the ISMS Fifty-Year Club.

*Indicates member of the Illinois State Medical Society.

Let's reciprocate

(Continued from page 270)

support and personnel to fulfill its function; and that the size of the committee should be increased as necessary to fulfill its function.

We trust that the appropriate ISMS committees will heed the majority of the House of Delegates and move with all deliberate speed to make true reciprocal licensing a reality. ◀

Editor Theodore R. Van Dellen, M.D.
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Microfilm copies of current as well as some back issues of the *Illinois Medical Journal* may be purchased from Xerox University Microfilms, 300 N. Zeeb Road, Ann Arbor, Mich., 48106.

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When irritable colon feels like this



The blowfish, a small species of fish, reacts to stress or fright by puffing itself up with air. After about a dozen noisy gulps the belly is balloon-shaped and hard. When replaced in the water the air is quickly expelled, and the fish sinks to the bottom.

BLUE SHIELD REPORT



FOR *Illinois Physicians*

NABSP President Notes 1969 Growth

In the 1969 annual report, John W. Castellucci, National Association of Blue Shield Plans president, noted that membership in the 74 Blue Shield Plans in the United States, Puerto Rico and Moncton, New Brunswick, increased by over 2.6 million persons during 1969.

This increase of 4.38 percent over 1968 brought total enrollment to 63.4 million or 31.25 percent of the population in the United States.

Blue Shield also provides services, under various government programs, for an additional 16.1 million persons.

During 1969, Blue Shield paid out a total of \$1.9 billion in benefits on behalf of its subscribers, up from \$1.7 billion the previous year. Benefits paid out for individuals served under government programs totaled another \$1.6 billion.

Castellucci cited many innovations during the past year. Among these were:

—Five million federal employees and members of their families are now covered under Blue

Shield and Blue Cross FEP programs, making this the largest underwritten group in existence.

—The British United Provident Association, with 1.5 million members has become an affiliate of NABSP.

—Blue Shield and Blue Cross have been working with local Plans to establish ongoing long-range systems procedures.

—Blue Shield's series of public information films on drug abuse were seen on television last year in over 100 cities across the nation, and two million copies of the drug abuse booklet were distributed.

Former SSA Official Protests NHI

In a speech before the annual convention of the Oklahoma State Medical Association this spring, Robert J. Myers, former Chief Actuary of the Social Security Administration, protested actions of those within SSA who are advocating a national health program.

Speaking just nine days before his resignation was accepted, Myers said these "social planners" use as their argument "the recent large increases in medical care costs."

He said they unfairly blame physicians for "sharply rising medical costs, when instead these are much more due to the rising general price and wage level and to the trend of hospital costs.

"If physicians had artificially held down their fees for Medicare patients, these men would no doubt have pointed out that Medicare was operating so well at low costs, that it should be extended to the entire population," Myers added. "You can't win."

Myers said that he was convinced that "the recent trend in physicians' fees is entirely justifiable in relation to other prices and to salary levels in general."

He criticized former Secretary Cohen for freezing physicians' fees for Medicare purposes. "These do not seem to me to be in accordance with the intent of the law."

If You Move Let Us Know

Incorrect addresses on physicians' bills are one of the major causes of delay in the processing of claims. Many offices have been using stationery with the old address when itemizing bills for beneficiaries.

To avoid these delays, please notify Blue Shield in writing of the address change. When writing, include the new and the old address.

Let us know, too, if you open a second office. This will help us to speed payments to you or to your patient.

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ASK BLUE SHIELD

• • • ABOUT MEDICARE

SSA Makes Changes in Lab Certification

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Berwyn, Illinois 60402

Mart X-ray Laboratory
7-110 Merchandise Mart
Chicago, Illinois 60654

Suburban Laboratories, Inc.
2137 South Lombard Avenue
Cicero, Illinois 60650

Should Hit Peak in 1972 Election

PRESSURE BUILDING UP OVER NATIONAL HEALTH INSURANCE

The battle for National Health Insurance didn't just begin. It's been going on since 1916, and was a national issue as far back as the Wagner Bill in 1939. Some of the present proponents of NHI have been working hard for it since the early 1930's.

In 1959, proponents of NHI changed tactics and decided to settle for a national health program for those over 65 as a temporary compromise. From 1959 until 1965 they fought for Medicare. From 1965 until recently, attention was on making Medicare work. But now that Medicare is working pretty well, the proponents of NHI feel their final objective is within reach.

If they run into stiff opposition, however, proponents might offer this compromise—make Medicare benefits broader, drop deductibles and coinsurance, and extend Medicare to the disabled and to children under 18. Presumably, this would be an interim goal, as was Medicare itself.

The proposals being developed will probably run along these lines.

Group One—Private insurance approach with federal government helping either the poor or everyone to purchase a minimum standard program through tax credits. Leading this group is the AMA.

Group Two—Medicare or Medicaid type approach administered by the federal government

Information Needed on Certifications

Though physicians are usually concerned with Part "B" (medical) of Medicare, a knowledge of Part "A" (hospital) benefits has become important since Utilization Review Committees have been in operation.

When reviewing the diagnosis and certification in order to provide Medicare benefits, you should keep in mind that while the certification does not have to be on any special form, it must contain the following information:

1. Reason for continued care. (A diagnosis alone is not acceptable.)
2. Estimated length of stay.
3. Plans for post hospital care.
4. It must be signed and dated. (Failure to date it would make the certification invalid.)

Also keep in mind that you may certify prior to the twelfth day, but if you sign after the twelfth day, a reason for the delay must be given. Otherwise, no benefits can be paid.

(Social Security Administration or a new agency) or state agencies, with option to use private carriers. This concept would involve a minimum standard program with the federal government paying for poor and others paying their own way as individuals or employer-employee groups. Of this group, Rep. John Dingell (D., Mich.) already has submitted a bill. Sen. Jacob Javits (R., N.Y.) may submit a bill to expand Medicare to all and possibly convert Blue Cross and Blue Shield into "public utilities" to administer his program.

Group Three—Comprehensive, cradle-to-grave, full coverage—compulsory for everyone—administered by federal government with built-in incentives to change the delivery system from fee-for-service to prepaid group practice.

Primary spokesmen for this group are the AFL-CIO and the UAW. Bills in this group will emphasize use of the financing system as a lever to effect change in the delivery system.

The crux of the problem isn't whether access to health care is a right—everyone agrees it is—or whether we should have some system of making it available—no one is opposed to that *per se*. The ways and means will be what the battle is about, and pressure for NHI should hit peak during the 1972 election.



J. Ernest Breed

The President's Page

Health care delivery changes loom

Catastrophic changes in the delivery of medical care are imminent. These are being brought about by several factors—increased demand, shortage of physicians and facilities, and the high cost of service. It is obvious the medical profession must update its delivery system, utilizing more allied medical personnel, modern communication systems, data storage and modern business methods.

Overwhelming pressures are brought about by the clamor for services from the public, the efforts of politicians to escape criticism for unfulfilled promises of free medical care, the demand of the socialists for complete medical care for all paid for by the "rich," and the declaration that health care is a "right." The pressure from the masses is predicated upon need and must be fulfilled, while the pressures from socialists chiefly give lip service to the needs of society while seeking control.

The proposed solutions are as numerous as the pressure groups. Before the House Ways & Means Committee is a plan fostered by Hew which would turn over to a not-for-profit organization a contract paying a fixed sum for the complete care of Medicare and Medicaid recipients. A similar system, embracing all people, is the aim of the socialists, spear-headed by the Citizens Committee of One Hundred, formerly headed by Walter Reuther. Realizing the necessity for some type of comprehensive insurance the AMA has had a bill introduced in Congress entitled "Medi-Credit." This is a plan to purchase comprehensive insurance with credit for the premium being al-

lowed on one's income tax and for government payment of the premiums for the indigent.

One thing is sure, no matter what final form we embrace, doctors in general are going to have to work in groups utilizing modern scientific facilities and many allied health assistants. For efficient service it is essential for physicians to control the groups.

Threatened with Kaiser Foundation closed panel groups, owned and operated by non-physicians, and with doctors on a salary, county medical Societies in Southern California organized "Health Care Foundations" providing full service, including hospitalization. Free choice of physician and fee-for-service are included. If a physician signed with the Foundation, he was obligated to accept a fixed fee for his services, based upon the California Relative Value Study. If he did not wish to sign up he understood that the fixed fee would be paid by the Foundation, and if his charges exceeded this fee he would have to collect the balance from the patient. The whole system is rigidly controlled by a Peer Review Committee of the physicians themselves.

The Foundations for Medical Care have been very successful and many more are in the process of formation. The State Medical Societies of Colorado and New Mexico are in the process of setting up statewide Foundations.

Doctors are fearful of closed panel groups such as the Kaiser Clinics, since the major concern of non-professional management

is money, not patient welfare. Only a few physicians would be employed in an area and doctors would lose control of the practice of medicine. Free choice as well as fee for service would be obviated.

It is reported that a number of hospitals in Illinois are contemplating setting up closed panel groups. For this reason a number of Illinois counties are seriously considering establishing Foundations for Medical Care.

I again urge Illinois doctors to voluntarily organize into corporate or partnership multi-discipline groups. If the doctors in an area are organized, obviously the federal government, unions or other organizations wishing to provide pre-paid care must negotiate with them. The control of medi-

cine then will remain in the hands of doctors.

On November 15, the ISMS will present a conference on "Health Care Delivery Changes in the 70's" at the Continental Plaza, Chicago. Arrangements have been made by Jacob Reisch, M.D., who stated "this will be the most important leadership conference we've ever had. Medicine is going to change drastically in the 1970's, whether we like it or not." Come to learn the problems and assist in finding the answers.

J. Ernest Breed M.D.



Membership Forum

September 2, 1970

Sir:

The plan as proposed by Dr. Samuel K. Lewis, in his article "Future Forensic Medicine in Illinois" (*IMJ*, March, 1970) is an ambitious pipe dream but not realistic fact. The number of medical schools that have chairs in the Forensic Sciences have dwindled to next to nothing, and at the present time the outlook remains dismal. Creating magnanimous centers is idealistic—the full-time staff is, however, not available. Every year, the American Board of Pathology certifies 15 or so pathologists in the specialized field of Forensic Pathology. This does not meet the needs of the country, and those of us certified—do not consider ourselves medical administrators.

The Baker Bill, the basic medical examiner law in the United States, with certain modifications, outlines very clearly what cases come under the jurisdiction and aegis of the medical examiner. The medical examiner's system is not new in the United States. It has been functioning in some jurisdictions since before the turn of the century. Replacing the lay coroner by a physician who is not trained or qualified to cope with problems that arise in the day to day operation of a medical examiner's office, does not improve the system. Training in hospital pathology does not give one expertise in the Forensic Sciences. The proposed seven regional centers, plus Cook County would be an exorbitant expense which the Illinois Legislature, or for that matter, any legislature, would refuse to support.

A more realistic approach, on a regional basis, would be to enlarge the facilities that are presently available or

could easily be made available and where expertise is already on hand. An example of that would be to funnel proposed Districts 1, 2, and 3 into the Office of the Chief Medical Examiner of the County of St. Louis, Missouri, or parts of Districts 3, 4, and 5 to expertise at the medical school in Iowa City, just across the river, and finally Districts 4, 5, 6, and 7 straight into the Chicago area. This type of redistricting, however, would preclude political rearrangement and lessening of local petty politics. In the long run, the tax payer, the person that should be served and who has to foot the bill, would be the winner.

Finally, although physicians must be the medical examiners and the system has to be encouraged by the medical society, it is the law enforcement and parajudicial agencies which must not only support, but actively co-operate with any well functioning system.

Sincerely,

Walter I. Hofman, M.D.

Medical Examiner, Dallas County

Southwestern Institute of Forensic Sciences at Dallas

Ed. note: Membership Forum is a means for the ISMS physician to express opinion and viewpoint on varied topics. If you have an item you would like brought before your fellow practitioners, please submit it to Membership Forum, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601. Communications should not exceed 250 words. The right to abstract or edit is reserved. Names will be withheld upon request, but anonymous letters will not be accepted.

ISMS ORGANIZATION

History of Founding and Expansion

TWENTY-NINE PHYSICIANS met in Springfield June 4, 1850, to organize on a permanent basis the Illinois State Medical Society, which had been started informally 10 years earlier. The founders were concerned with the solution of ethical, scientific, legislative and economic problems. The first Constitution and Bylaws and the first Code of Medical Ethics were adopted; the first legislative committee was appointed, and a resolution outlining the beginnings of interprofessional relations was approved.

The Legislative Committee was instructed to "memorialize the legislature at its next session, praying the enactment of a statute providing for the registration of Births, Deaths and Marriages." The resolution ruled that "members of the Society will discourage the sale of patent or secret nostrums on the part of Druggists and Apothecaries throughout the State, and will patronize insofar as practicable, only those who abstain from the sale of such patent or secret nostrums."

The first full time secretary of the Society was Dr. Harold M. Camp who served for over 35 years until his death in 1958. The first executive administrator, Robert L. Richards, was employed at the time the office was moved to Chicago in 1960 and served until February, 1966. After an interim service by Dr. George F. Lull, Mr. Roger N. White was selected as Executive Administrator in May, 1968.

The Society published the early transactions in

book form presenting not only the minutes of the House of Delegates, but also all scientific papers given at each annual convention. In 1898 a new era of communications began, for at that time, the *Illinois Medical Journal* was established and became the first "official organ of the Society."

Dr. G. N. Kreider was its first editor and served until 1913, followed by Dr. Clyde D. Pence with Dr. Henry G. Olds as the first managing editor. Dr. Charles G. Whalen became editor in 1919 and he and Dr. Olds served until they died in 1940. Dr. Camp followed Dr. Whalen and Dr. Theodore R. Van Dellen is the editor today.

Dr. Whalen spearheaded many important activities in medicine, and has been called "the outstanding champion of the medical profession in its economic contacts." He has been credited as one of the first medical editors to blast "the socialization of medicine in this country." In 1922 he wrote extensively on state medicine, workmen's compensation, compulsory health insurance, free hospitalization and federal aid.

The first Fifty Year Club in the United States was announced by the *Illinois Medical Journal* in 1938.

The fourth largest medical society in the country has developed from these embryonic beginnings. This edition of the *Illinois Medical Journal* offers you an opportunity to contrast the extensive services available to the membership today with those offered in the past.

OFFICERS AND PLACES OF MEETING

YEAR	PRESIDENT	SECRETARY	TREASURER	MEETING PLACE
1840	John Todd	David Prince		Springfield
1850	Rudolph Rouse	Edwin G. Meek		Springfield
1850	William B. Herrick	Edwin G. Meek	Jno. Halderman	Springfield
1851	Samuel Thompson	H. Shoemaker	R. Rouse	Peoria
1852	Rudolph Rouse	E. S. Cooper	Edw. Dickenson	Jacksonville
1853	Daniel Brainerd	H. A. Johason	A. B. Chambers	Chicago
1854	C. N. Andrews	H. A. Johason	N. S. Davis	LaSalle
1855	N. S. Davis	E. Andrews	J. V. Z. Blaney	Bloomington
1856	H. Noble	N. S. Davis	J. V. Z. Blaney	Vandalia
1857	C. Goodbreak	H. A. Johnson	J. V. Z. Blaney	Chicago
1858	H. A. Johnson	N. S. Davis	J. W. Freer	Rockford
1859	David Prince	N. S. Davis	J. W. Freer	Decatur
1860	Wm. M. Chambers	N. S. Davis	J. W. Freer	Paris
1863	A. McFarland	N. S. Davis	J. H. Hollister	Jacksonville
1864	A. H. Luce	N. S. Davis	J. H. Hollister	Chicago
1865	J. M. Steele	N. S. Davis	J. H. Hollister	Bloomington
1866	F. F. Haller	N. S. Davis	J. H. Hollister	Decatur
1867	H. Noble	N. S. Davis	J. H. Hollister	Springfield
1868	S. T. Trowbridge	N. S. Davis	J. H. Hollister	Quincy
1869	S. T. Trowbridge	T. D. Fitch	J. H. Hollister	Chicago
1870	J. V. Z. Blaney	T. D. Fitch	J. H. Hollister	Dixon
1871	G. W. Albin	T. D. Fitch	J. H. Hollister	Peoria
1872	J. O. Hamilton	T. D. Fitch	J. H. Hollister	Rock Island
1873	D. W. Young	T. D. Fitch	J. H. Hollister	Bloomington
1874	T. F. Worrell	T. D. Fitch	J. H. Hollister	Chicago
1875	J. H. Hollister	T. D. Fitch	Wm. E. Quine	Jacksonville
1876	T. D. Washburn	N. S. Davis	J. H. Hollister	Urbana
1877	T. D. Fitch	N. S. Davis	J. H. Hollister	Chicago
1878	J. L. White	N. S. Davis	J. H. Hollister	Springfield
1879	E. P. Cook	N. S. Davis	J. H. Hollister	Lincoln
1880	Ephraim Ingalls	N. S. Davis	J. H. Hollister	Belleville
1881	G. W. Jones	S. J. Jones	J. H. Hollister	Chicago
1882	Robert Boal	S. J. Jones	J. H. Hollister	Quincy
1883	A. T. Darrah	S. J. Jones	J. H. Hollister	Peoria
1884	E. Andrews	S. J. Jones	Walter Hay	Chicago
1885	D. S. Booth	S. J. Jones	Walter Hay	Springfield
1886	Wm. A. Byrd	S. J. Jones	Walter Hay	Bloomington
1887	Wm. T. Kirk	D. W. Graham	Walter Hay	Chicago
1888	Wm. O. Ensign	D. W. Graham	Walter Hay	Rock Island
1889	C. W. Earle	D. W. Graham	T. W. McIlvaine	Jacksonville
1890	John Wright	D. W. Graham	T. W. McIlvaine	Chicago
1891	Jno. P. Mathews	D. W. Graham	Geo. N. Kreider	Springfield
1892	Charles C. Hunt	D. W. Graham	Geo. N. Kreider	Vandalia
1893	E. Fletcher Ingals	D. W. Graham	Geo. N. Kreider	Chicago
1894	Otho B. Will	J. B. Hamilton	Geo. N. Kreider	Decatur
1895	Daniel R. Brower	J. B. Hamilton	Geo. N. Kreider	Springfield
1896	D. W. Graham	J. B. Hamilton	Geo. N. Kreider	Ottawa
1897	A. C. Corr	J. B. Hamilton	Geo. N. Kreider	East St. Louis
1898	J. N. G. Carter	E. W. Weis	Geo. N. Kreider	Galesburg
1899	J. T. Pitner	E. W. Weis	Geo. N. Kreider	Cairo
1900	H. N. Moyer	E. W. Weis	Geo. N. Kreider	Springfield
1901	G. N. Kreider	E. W. Weis	E. J. Brown	Peoria
1902	J. T. McAnally	E. W. Weis	E. J. Brown	Quincy
1903	M. L. Harris	E. W. Weis	E. J. Brown	Chicago
1904	C. E. Black	E. W. Weis	E. J. Brown	Bloomington
1905	W. E. Quine	E. W. Weis	E. J. Brown	Rock Island
1906	H. C. Mitchell	E. W. Weis	E. J. Brown	Springfield
1907	J. F. Percy	E. W. Weis	E. J. Brown	Rockford
1908	W. L. Baum	E. W. Weis	E. J. Brown	Peoria
1909	I. W. Pettit	E. W. Weis	E. J. Brown	Quincy
1910	J. L. Wiggins	E. W. Weis	E. J. Brown	Danville
1911	A. C. Cotton	E. W. Weis	E. J. Brown	Aurora

YEAR	PRESIDENT	SECRETARY	TREASURER	MEETING PLACE
1912	W. K. Newcomb	E. W. Weis	E. J. Brown	Springfield
1913	L. H. A. Nickerson	E. W. Weis	A. J. Markley	Peoria
1914	Charles J. Whalen	W. H. Gilmore	A. J. Markley	Decatur
1915	A. L. Brittin	W. H. Gilmore	A. J. Markley	Springfield
1916	C. W. Lillie	W. H. Gilmore	A. J. Markley	Champaign
1917	W. L. Noble	W. H. Gilmore	A. J. Markley	Bloomington
1918	E. B. Coolley	W. H. Gilmore	A. J. Markley	Springfield
1919	E. W. Fiegenbaum	W. H. Gilmore	A. J. Markley	Peoria
1920	J. W. Van Derslice	W. H. Gilmore	A. J. Markley	Rockford
1921	W. F. Grinstead	W. H. Gilmore	A. J. Markley	Springfield
1922	Charles Humiston	W. H. Gilmore	A. J. Markley	Chicago
1923	E. P. Sloan	W. D. Chapman	A. J. Markley	Decatur
1924	E. H. Ochsner	W. D. Chapman	A. J. Markley	Springfield
1925	L. C. Taylor	H. M. Camp	A. J. Markley	Quincy
1926	J. C. Krafft	H. M. Camp	A. J. Markley	Champaign
1927	Mather Pfeifferberger	H. M. Camp	A. J. Markley	Moline
1928	G. Henry Mundt	H. M. Camp	A. J. Markley	Chicago
1929	J. E. Tuite	H. M. Camp	A. J. Markley	Peoria
1930	F. O. Fredrickson	H. M. Camp	A. J. Markley	Joliet
1931	Wm. D. Chapman	H. M. Camp	A. J. Markley	East St. Louis
1932	R. R. Ferguson	H. M. Camp	A. J. Markley	Springfield
1933	John R. Neal	H. M. Camp	A. J. Markley	Peoria
1934	Philip H. Kreuscher	H. M. Camp	A. J. Markley	Springfield
1935	Charles D. Center*			
(Past President-Elect)				
1935	Charles S. Skaggs	H. M. Camp	A. J. Markley	Rockford
1936	Chas. B. Reed	H. M. Camp	A. J. Markley	Springfield
1937	Rolland L. Green	H. M. Camp	A. J. Markley	Peoria
1938	R. K. Packard	H. M. Camp	A. J. Markley	Springfield
1939	S. E. Munson	H. M. Camp	A. J. Markley	Rockford
1940	Jas. H. Hutton	H. M. Camp	A. J. Markley	Peoria
1941	J. S. Templeton	H. M. Camp	A. J. Markley	Chicago
1942	Chas. H. Phifer	H. M. Camp	H. M. Camp	Springfield
1943	E. H. Weld	H. M. Camp	H. M. Camp	Chicago
1944	G. W. Post**	H. M. Camp	H. M. Camp	Chicago
1945	E. P. Coleman	H. M. Camp	H. M. Camp	***
1946	E. P. Coleman	H. M. Camp	H. M. Camp	Chicago
1947	R. S. Berghoff	H. M. Camp	H. M. Camp	Chicago
1948	I. H. Neece	H. M. Camp	H. M. Camp	Chicago
1949	Percy E. Hopkins	H. M. Camp	H. M. Camp	Chicago
1950	Walter Stevenson	H. M. Camp	H. M. Camp	Springfield
1951	Harry M. Hedge	H. M. Camp	H. M. Camp	Chicago
1952	C. Paul White	H. M. Camp	H. M. Camp	Chicago
1953	Leo P. A. Sweeney	H. M. Camp	H. M. Camp	Chicago
1954	Willis I. Lewis	H. M. Camp	H. M. Camp	Chicago
1955	Arkell M. Vaughn	H. M. Camp	H. M. Camp	Chicago
1956	F. Garm Norbury	H. M. Camp	H. M. Camp	Chicago
1957	F. Lee Stone	H. M. Camp	H. M. Camp	Chicago
1958	Lester S. Reavley	H. M. Camp	H. M. Camp	Chicago
1959	Raleigh C. Oldfield	H. M. Camp	H. M. Camp	Chicago
1960	Joseph T. O'Neill	George F. Lull	George F. Lull	Chicago
1961	H. Close Hesseltine	Jacob E. Reisch	Jacob E. Reisch	Chicago
1962	Edwin S. Hamilton	Jacob E. Reisch	Jacob E. Reisch	Chicago
1963	George F. Lull	Jacob E. Reisch	Jacob E. Reisch	Chicago
1964	Harlan English	Jacob E. Reisch	Jacob E. Reisch	Chicago
1965	Edward A. Piszczek	Jacob E. Reisch	Jacob E. Reisch	Chicago
1966	Burtis E. Montgomery	Jacob E. Reisch	Jacob E. Reisch	Chicago
1967	Caesar Portes	Jacob E. Reisch	Jacob E. Reisch	Chicago
1968	Newton DuPuy	Jacob E. Reisch	Jacob E. Reisch	Chicago
1969	Philip G. Thomsen	Jacob E. Reisch	Jacob E. Reisch	Chicago
1970	Edward W. Cannady	Jacob E. Reisch	Jacob E. Reisch	Chicago
1971	J. Ernest Breed	Jacob E. Reisch	Jacob E. Reisch	Chicago

*Died before induction into office
 **Died in office. Term completed by Robert S. Berghoff, First Vice President
 ***Meeting cancelled 1945

Principles Of Medical Ethics

PREAMBLE: These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

SECTION 1—The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

SECTION 2—Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

SECTION 3—A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

SECTION 4—The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

SECTION 5—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving

adequate notice. He should not solicit patients.

SECTION 6—A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

SECTION 7—In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

SECTION 8—A physician should seek consultation upon request, in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

SECTION 9—A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

SECTION 10—The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

Constitution And Bylaws

May 1970

Adopted, 1903
As Amended, 1970

CONSTITUTION

ARTICLE I. NAME

The name and title of this organization shall be the Illinois State Medical Society.

ARTICLE II. PURPOSES OF THE SOCIETY

The purposes of this Society are to promote the science and art of medicine, to protect the public health, to elevate the standards of medical education and to unite the medical profession behind these purposes; to promote similar interests in the component societies and to unite with similar organizations in other states and territories of the United States to form the American Medical Association. The Society shall inform the public and the profession concerning the advancements in medical science and the advantages of proper medical care.

ARTICLE III. COMPONENT SOCIETIES

Component societies shall consist of those county medical societies which hold charters from this Society.

ARTICLE IV. COMPOSITION OF THE SOCIETY

The Society shall consist of active members and such other members as the Bylaws may provide.

ARTICLE V. HOUSE OF DELEGATES

Section 1. The House of Delegates shall be the legislative body of the Illinois State Medical Society, and unless otherwise herein provided, its deliberations shall be binding upon the officers, including the Board of Trustees. The House of Delegates shall set the basic policy and philosophy of the Society.

Section 2. The House of Delegates shall elect the general officers, except as otherwise provided in the Bylaws.

ARTICLE VI. BOARD OF TRUSTEES

The Board of Trustees, whose duties are executive and judicial, shall have charge of all property and all financial affairs of the Society, and shall perform such other duties as are prescribed by law governing the directors of corporations, or as may be prescribed in the Bylaws.

ARTICLE VII. CONVENTIONS AND MEETINGS

The Society shall hold an annual convention during which there shall be a business meeting of the House of Delegates and general scientific meetings which shall be open to all registered members.

ARTICLE VIII. OFFICERS

The officers of this Society shall be a president, a president-elect, a first vice president, a second vice president, a secretary-treasurer, a speaker and vice speaker of the House of Delegates, sixteen trustees and one trustee at large, and such other officers as the Bylaws may provide.

ARTICLE IX. THE SEAL

This Society shall have a common seal with power to break, change or renew the same when necessary.

ARTICLE X. AMENDMENTS

The House of Delegates may amend this Constitution at any annual business meeting of the House of Delegates provided that the amendment shall have been proposed at the preceding annual business meeting, and that two-thirds of the members of the House of Delegates seated concur in the amendment.

BYLAWS

CHAPTER I. MEMBERSHIP

Section 1. *Members.*

A. *Active Members.* The active members of this Society shall consist of regular members, emeritus members, retired members, provisional members, intern members and residency members. Active members shall enjoy full privileges which include membership in the American Medical Association.

B. *Special Members.* The special members of this Society shall be distinguished because of their contributions to the science and art of medicine.

(1) *Distinguished Members.* Distinguished members shall be:

a. Physicians of Illinois or other states, or foreign countries who have risen to prominence in the profession; or

- b. Teachers of medicine or of the sciences allied to medicine, not eligible for active membership; or
 - c. Members of associated arts or sciences who have made significant contributions to medicine.
- (2) *Election.* Special members may be nominated by any member of the House of Delegates, and may be elected by the House at any annual convention by a two-thirds vote.
- (3) *Privileges.* Special members shall not be entitled to hold office nor to vote, and shall not be considered as members in determining the number of delegates to the American Medical Association, but they may participate in all other Society activities.

Section 2. *Qualifications for Membership.*

- A. Every physician duly licensed and registered in the State of Illinois to practice medicine in all its branches who is a resident of the State of Illinois, a citizen of the United States, who is of good moral character and professional standing, and a member of his component medical society, shall be eligible for regular membership.
- B. Provisional membership shall be available to any Illinois physician who has made a declaration of intention to become a citizen of the United States, who has received a license in this State to practice medicine in all of its branches, and who—with the exception of United States citizenship—possesses all of the qualifications for membership prescribed by these Bylaws. Provisional membership shall terminate one year after the expiration of the minimum period of time within which such member could have perfected his citizenship. After obtaining full citizenship and prior to the expiration of his provisional membership, such member may be, upon application to his component medical society, transferred to regular membership.
- C. The following shall also be eligible if approved and recommended by the component medical society:
- (1) Every physician serving as a full time employee at the headquarters of the American Medical Association;
 - (2) Physicians serving as medical officers in the United States Governmental Services, who are members of a component society, so long as they are engaged actively full-time in their respective service, and thereafter, if they have been retired on account of age or physical disability, or after long and honorable service under the provision of an Act of Congress;

D. Physicians otherwise eligible for membership, and licensed in one of the States of the Union, but not licensed in Illinois, and who are not engaged in the active practice of medicine, but otherwise employed in an allied medical activity which does not require licensure, shall be eligible for membership if approved and recommended by the component medical society and approved by the Board of Trustees.

Section 3. *Emeritus Members.* A member to be elected to emeritus membership shall:

currently be in good standing, have been a member in good standing for 35 years, have reached, or will have reached before the next fiscal year, the age of 70 years, and have made written application to and have been recommended by his component society for emeritus status.

Such membership shall become effective January 1 of the year following election. Emeritus members shall have all the rights and privileges of membership without the payment of dues to the component or state society.

Credit for membership in other American Medical Association constituent societies shall be accorded transferees, provided they have been members of this Society for at least five years.

Section 4. *Retired Members.* A member who has been in good standing but who by reason of age or incapacity, has retired from active practice, may upon application to and upon recommendation of his component society, be made a retired member, without payment of dues to the component or state society.

Section 5. *Intern Members.* Any person who is a graduate of a medical school, who is of good moral character and professional standing and serving an internship in any hospital in the State of Illinois approved by the American Medical Association, is eligible for intern membership upon the recommendation of any two members of this Society who are also members of his hospital staff.

The physician's intern membership shall cease at the end of the year in which his internship training terminates, and if he wishes to become a member of this Society, he must apply for a residency or regular membership through his component society.

Dues for intern membership shall be minimal.

Section 6. *Residency Members.* After being licensed to practice medicine, a physician serving full time as a resident in a residency approved by the American Medical Association, is eligible for full membership.

Dues for residency members shall be minimal.

A residency member must be a graduate of a medical school, have a degree of Doctor of Medicine or its equivalent, and must be a member in good standing of his component society.

The physician's residency membership shall cease at the end of the year in which his residency training terminates, and if he wishes to become a member of this Society, he must apply for regular membership through his component society.

Section 7. *Tenure of Membership.* The name of a physician on the properly certified roster of members of a component society which has paid its annual assessments, shall be prima facie evidence of membership in this Society, and afford all the rights and privileges pertaining thereto.

Section 8. *Withdrawal of Privileges.* No person who is under sentence of suspension or expulsion from a component society, shall be entitled to any of the rights or benefits of this Society, nor shall he be permitted to take part in any of the proceedings until he has been reinstated.

Section 9. *Student Committee Membership.* Students nominated by Illinois Chapters of the Student American Medical Association, or other recognized student organizations approved by the Illinois State Medical Society Board of Trustees, to serve with Illinois State Medical Society members on appropriate committees, may by action of the Board of Trustees, be accorded membership in this classification for the term of the committee appointment. Such members shall be permitted full privileges of committee membership, including (with permission of the House of Delegates) the right to speak on the floor of the House, but shall have no vote out of committee. They shall pay no dues.

CHAPTER II. ANNUAL CONVENTIONS

Section 1. *Date.* The Board of Trustees shall determine the date for the annual convention.

Section 2. *Meeting Place.* The meeting place for the annual convention shall be determined by the House of Delegates from a list of cities extending invitations, subject to investigation of the facilities and recommendation by the Board of Trustees.

Section 3. *Scientific Meetings.*

- A. With the consent of the House of Delegates or the Board of Trustees any special group may conduct its meeting in connection with the annual convention of this Society.
- B. The Scientific Program shall be conceived by the Committee on Scientific Assembly and developed and implemented through the joint efforts of the Committee on Scientific Assembly and representatives of specialty groups.
- C. All registered members may attend and participate in the proceedings and discussions of the general scientific meetings and of the section meetings.
- D. The general scientific meetings may recommend to the House of Delegates the appoint-

ment of committees or commissions for scientific investigation of special interest and importance to the profession and to the public.

E. All papers read before the Society or any section thereof, shall become the property of the Society. Each paper shall be deposited with the secretary when read, and presentation of a paper to the Illinois State Medical Society shall be considered tantamount to the assurance on the part of the writer that such paper has not already been published.

F. The Board of Trustees shall be entirely responsible for the annual convention.

CHAPTER III. THE HOUSE OF DELEGATES

Section 1. *Composition.* The voting membership of the House of Delegates shall consist of:

- A. Delegates elected by the component societies
- B. The president
- C. The president-elect
- D. The secretary-treasurer
- E. The speaker of the House (or the vice speaker when presiding) and
- F. The trustees.

Non-voting members shall be the vice presidents, the vice speaker (when not presiding), the past trustees, past speakers, past presidents, general officers of the AMA and delegates from the Illinois State Medical Society to the AMA.

Section 2. *Meetings.* The House of Delegates shall meet at the time and place of the annual convention of the Society, and shall fix its hours of meeting so that they shall not conflict with the general scientific meetings of the Society. If the interests of the Society and the profession require, the House of Delegates may meet in advance of the general scientific meetings.

Section 3. *Quorum.* Fifty delegates representing not less than twenty component societies shall constitute a quorum for the transaction of business.

Section 4. *Special Meetings.* Special meetings of the House of Delegates may be called by the president or a majority of the Board of Trustees, or shall be called on petition of twenty component societies.

When a special meeting is thus called, the secretary shall mail a notice to the last known address of each member of the House of Delegates at least ten days before the special meeting is to be held. The notice shall specify the time and place of the meeting and the purpose for which the meeting is called. The meeting shall not consider any business except that for which it was called.

Section 5. *Delegates.*

A. Component Societies. Each component society shall be entitled to send to the House of Delegates each year, one delegate for each 75 members, and one for a major fraction thereof;

but each component society which has made its annual report and paid its assessment as provided for in this Constitution and Bylaws, shall be entitled to one delegate.

The number of delegates to which any component society is entitled shall be determined by the number of active members of the component society on the membership rolls of the Illinois State Medical Society as of December 31 of the preceding year.

The term of office of a delegate shall begin January 1 following his election, and shall be for two years, or until his successor has been elected. Component societies with one delegate only, may elect for one year.

B. Affiliated Groups. The combined Illinois chapters of the Student American Medical Association shall be considered a single affiliate group.

1. *Representation.* The Student American Medical Association, as an affiliate group, shall be entitled to one delegate and one alternate delegate to serve in the House of Delegates with vote.

2. *Term of office.* The term of office of a delegate shall begin January 1, following his election, and shall be for two years, or until his successor has been elected.

Section 6. Registration. Before being seated at any annual or special session, each delegate or his alternate shall deposit with the Reference Committee on Credentials a certificate signed by the president and/or the secretary of the component society, stating that the delegate or alternate has been regularly elected to the House of Delegates.

A delegate or his alternate may be seated without credentials, provided he is properly identified and so certified to the secretary of the Illinois State Medical Society.

Whenever a delegate or his alternate are both unable to attend a particular meeting, the component society may select and certify a substitute delegate who shall have the same powers and duties as did the delegate.

A delegate whose credentials have been accepted by the Reference Committee on Credentials and whose name has been placed on the roll of the House, shall remain a delegate until final adjournment of that session. If a delegate, once seated, is unable to be present for reasons acceptable to the Committee on Credentials, an alternate may be certified by that Committee. After the alternate has been seated, he cannot be replaced for that session.

Section 7. AMA Delegates and Alternate Delegates. The House of Delegates shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

Section 8. District Divisions. The House of Dele-

gates shall divide the state into districts, specifying which counties each district shall include.

Section 9. Committees. The House of Delegates may authorize the appointment of ad hoc committees by the president, who shall first consult with the president-elect.

The president shall have authority to designate to serve on ad hoc committees, members of the Society who are not members of the House and who may be present and permitted to participate in the debate when the report of the committee is considered.

CHAPTER IV. ELECTION OF OFFICERS

Section 1. Officers. The officers of this Society shall consist of the president, president-elect, first and second vice presidents, secretary-treasurer, speaker and vice speaker, sixteen trustees and one trustee-at-large.

Section 2. Elections. All elections shall be by ballot except when there is only one candidate for a given office, then election may be by voice vote.

The majority of votes cast shall be necessary to elect.

The election of officers, delegates and alternate delegates to the AMA, shall follow the completion of action on current and old business at the final session of the House of Delegates.

Section 3. Terms of Office. The president-elect, vice presidents, secretary-treasurer, the speaker and vice speaker shall be elected annually by the House of Delegates to serve for a term of one year.

Members of the Board of Trustees shall be elected by the House of Delegates to serve for a term of three years.

The speaker and vice speaker shall not be elected for more than three consecutive terms to their respective offices; they shall be elected from the membership of the House of Delegates.

The president-elect shall be inducted into the office of president by the retiring president during the final session of the House of Delegates. After assuming office at the adjournment of the annual business meeting, he shall continue in office until his successor has been elected and installed. Following his retirement as president, he shall automatically become a trustee-at-large for a term of one year.

CHAPTER V. DUTIES OF OFFICERS

Section 1. The President. The president of the Illinois State Medical Society shall lead the Society in all its functions. He shall deliver an annual address at such time as may be arranged, and perform such other duties as custom and parliamentary usage may require.

The president shall appoint the ad hoc committees of the House of Delegates. He may seek the advice of the officers and trustees.

He shall preside at the general scientific meetings

of the Society or designate one of the vice presidents to substitute for him.

Section 2. *The Vice Presidents.* The vice presidents shall act for and perform such duties for the president as he shall direct. They shall, when so acting, implement and advance the programs and policies of the president.

In the event of the president's death, resignation or removal from office, the first vice president shall succeed to the presidency.

In the event of a vacancy in the office of first vice president, the president shall fill the office by appointment.

Section 3. *Successor to President-Elect.* In the case of death, resignation, or removal from office of the president-elect, the office shall be filled by the House of Delegates at the next annual convention by election at a time recommended by the Reference Committee on Rules and Order of Business.

Section 4. *The Speaker.* The speaker, who shall be versed in parliamentary procedure, shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

He shall appoint the reference committees.

He shall be an ex-officio member of the Committee on Constitution and Bylaws.

Section 5. *The Vice Speaker.* The vice speaker shall preside for the speaker in the latter's absence or at his request. In case of death, resignation or inability of the speaker to perform his duties, the vice-speaker shall serve during the unexpired term.

Section 6. *The Secretary-Treasurer.* In addition to the rights and duties ordinarily devolving on the secretary of a corporation by law, custom or parliamentary usage, and those granted or imposed in other provisions of the Constitution and these Bylaws, the secretary-treasurer shall be the official custodian of all securities and the income therefrom, owned by the Society, subject to the direction and disposition of the Board of Trustees. He shall be a member of the Finance Committee of the Board of Trustees.

The Board of Trustees may select a bank or trust company to act as custodian in the place of the secretary-treasurer, of all or any part of such securities and to act as agent of the Society in collecting the income therefrom.

He shall perform such other duties as may be directed by the House of Delegates or by the Board of Trustees.

In the event of a vacancy in the office of the secretary-treasurer, the Board of Trustees shall fill the vacancy until the next annual election.

CHAPTER VI. THE BOARD OF TRUSTEES

Section 1. *Composition.* The Board of Trustees shall consist of sixteen trustees elected by the

House of Delegates [six shall be chosen from district number three, and one from each of the other ten districts (see map attached), these districts of the geographical area as of May, 1946], and one trustee-at-large (the retiring president, who shall serve a term of one year), the president, the president-elect, the speaker and secretary-treasurer.

The vice presidents and vice speakers shall attend the meetings (including executive sessions), with the right of discussion, but without the right to vote.

Section 2. The duties of the Board of Trustees are executive, custodial and judicial.

A. *Executive Duties.* The Board of Trustees shall implement all mandates from the House of Delegates except in matters of property or finance when it shall have sole authority.

The Board of Trustees may request a report from any committee in the interim between meetings of the House of Delegates.

B. *Custodial Duties.* The Board of Trustees shall have charge and control of all property of whatsoever nature belonging to the Society, and of all funds from whatsoever source belonging to the Society.

No person shall expend or use for any purpose money belonging to the Society without the approval of the Board of Trustees.

All money received by the Board of Trustees and its agents, resulting from the duties assigned them, shall be paid into the treasury of the Society, and all orders on the treasury for disbursement of money shall be approved by the Board.

The Board of Trustees shall formulate rules governing the expenditure of money to meet the necessary running expenses and fixed charges of the Society.

All acts of the House of Delegates involving the expenditure, appropriation or use in any manner of money, or the acquisition or disposal in any manner of property of any kind belonging to the Society, must be approved by the Board of Trustees before same shall become effective.

Funds may be appropriated to encourage scientific investigation, medical education or any other purpose deemed proper and approved by the Board of Trustees.

C. *Judicial Duties.* The Board of Trustees shall be the board of censors of the Society. It shall have jurisdiction over all questions of ethics and in the interpretation of the laws of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to component societies, or to this Society.

All questions of an ethical nature before the House of Delegates or the general scientific meetings, shall be referred to the Board

of Trustees without discussion. The Board shall hear and decide all questions of procedure affecting the conduct of members on which an appeal is taken from the decision of a component society.

The decision of the Board of Trustees shall be final except that an appeal may be taken by a member charged with misconduct as provided for in the Constitution and Bylaws of the American Medical Association.

Section 3. *Executive Administrator.* The Board of Trustees shall employ an executive administrator (who, when he shall be a physician, may be designated as the executive vice-president) whose duties shall be determined by the Board. He shall be responsible to the chairman of the Board. The Board shall review at each of its meetings the interim activities of the administrator. The Board shall also employ such other people as are needed for the conduct of the affairs of the Society.

Section 4. *Meetings.* The Board of Trustees shall meet daily during the annual convention of the Society, and at such other times as necessity may require, subject to the call of the chairman, or on the petition of the majority of the Trustees.

Section 5. *Organization.*

A. *Chairman.* The Board of Trustees shall meet on the last day of the annual convention and elect from among its members a chairman. He shall hold office for one year and may succeed himself for one additional year.

B. *Duties of the Chairman.* The chairman of the Board of Trustees shall prepare an agenda and shall preside at all meetings of the Board. He shall make an annual report to the House of Delegates. He shall be chairman of the Executive Committee. He shall present the report of the actions of the Executive Committee to the Board.

Section 6. *Quorum.* Ten members of the Board of Trustees shall constitute a quorum for the transaction of business.

Section 7. *County Societies.* The Board of Trustees shall have authority to organize the physicians of two or more counties into societies to be suitably designated, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

Section 8. *Publications.* The Board of Trustees shall provide and superintend the publication and the distribution of all proceedings, transactions and memoirs of the Society, and shall have authority to appoint an editor and such assistants as it deems necessary.

Section 9. *Bonding.* The Board of Trustees shall provide at the expense of the Society, adequate

bond for those officers and employees of the Society it considers require bonding.

Section 10. *Duties of Trustees.* Each trustee shall be the organizer, consultant, advisor, administrator and speaker for the members of his district, and represent the Society as well as the members of his district at the Board meetings.

Each trustee should visit the societies in his district at least once a year. He shall make an annual report of his work and the condition of the profession in each society in his district to the Board of Trustees and to the House of Delegates.

Where his district is composed of more than one county, the trustee shall be an ex-officio member of the district Ethical Relations Committee, Grievance Committee, and Prepayment Plans and Organizations Committee. He shall report to the Board of Trustees the actions of the component societies on reports of these committees.

The necessary traveling expenses incurred by such trustee in the line of the duties herein imposed, may be allowed by the Board of Trustees upon presentation of a properly itemized statement.

Section 11. *Vacancies.* If during the interval between two annual conventions, sickness, death, or removal from the state or district, or any other reason prevents a trustee from attending the duties of his district, or if he shall be absent from two consecutive meetings of the Board, his office may be declared vacant at the discretion of the Board. The Board shall have the authority to fill the vacancy for the period between the date at which the office was declared vacant and the next annual meeting of the House of Delegates.

Section 12. *The Benevolence Fund.* Each year the Board shall appropriate from the funds of this Society such sum or sums as it may deem proper to be held in a fund to be known as "The Benevolence Fund." This fund is established and shall be used only for the assistance or relief of needy members of this Society, their widows, widowers, or minor children. The assets shall be held in the treasury of this Society in a separate fund. Donations or bequests to the Benevolence Fund automatically become a part of these assets.

Section 13. *Audit and Financial Statement.* The Board of Trustees shall employ annually a certified public accountant to audit all accounts of the Society, and present a statement of same in its annual report to the House of Delegates.

This report shall also specify the character and cost of all publications of the Society during the year, and the amount of all other property belonging to the Society under its control, with such suggestions as it may deem necessary.

CHAPTER VII. DISTRICT COMMITTEES

Each trustee district which is composed of more than one county, shall have an Ethical Relations

Committee, a Peer Review Committee, and such other committees as required to provide to each component society, those services the component society may not be able to provide for itself. District committees shall function only at the request of a component society within the district.

Complaints initially received by district committees shall be referred immediately to the component society for action.

District committees shall be governed by the procedural rules and regulations governing the counterpart state society committee or by these Bylaws.

Reports of findings and recommendations of these district committees shall be made to the component society which requested action.

The district trustee shall include a summary of the activities of each of these committees and the findings in general, in his annual report to the House of Delegates.

The committee members shall be elected at a meeting of the delegates of the district called by the trustee of the district, before or during the annual convention of the Illinois State Medical Society. Chairmen of the committees shall be designated by the trustee of the district, and the trustee shall be an ex-officio member of each committee.

CHAPTER VIII. DUES AND EXPENSES

Section 1. *Annual Dues.* Assessments may be levied by the House of Delegates on each component society on a proportional basis. The amount of the dues shall be fixed by the House of Delegates and shall include the dues and/or assessments approved by the House of Delegates of the American Medical Association.

These annual dues shall include the annual subscription to the Illinois Medical Journal which shall be at least fifty per cent of the regular subscription price of the Journal.

Section 2. The Board of Trustees upon recommendation of the component society, shall give 50% reduction in dues to teaching, research and administrative personnel in full time employment in the approved medical schools in Illinois, or similar not-for-profit institutions in Illinois.

Section 3. Physicians in private practice of medicine may be given a 50% reduction in dues during the first year of practice upon recommendation of their component society.

Section 4. Physicians approved for membership after June 30 shall pay one-half of the annual dues for that year.

Section 5. The Board of Trustees may authorize the remission of dues of any member on recommendation of his component society for good reason. In such cases the secretary shall recommend

remission of dues by the American Medical Association.

CHAPTER IX. COMMITTEES

Part 1. Councils and Committees

Section 1. *Councils and Committees*

The councils and committees of the Illinois State Medical Society shall be:

- A. Councils (Standing committees)
- B. Reference committees of the House of Delegates
- C. Board of Trustees committees

Section 2. The appointing authority may alter council and/or committee membership and assign or delete duties as it deems necessary.

PART 2. Councils.

Section 1. The Councils of the Society shall be:

- A. Medical-Legal Council
- B. Council on Legislation & Public Affairs
- C. Council on Education and Manpower
- D. Council on Economics and Peer Review
- E. Council on Environmental and Community Health
- F. Council on Public Relations and Membership Services
- G. Council on Mental Health and Addiction
- H. Council on Social and Medical Services; and such other Councils as may be established from time to time by the Board of Trustees.

Section 2. *Organization of Councils.*

- A. Councils shall be appointed by the Board of Trustees.
- B. The chairman of a Council shall be designated by the Board. He may not serve as chairman of any committee of the Council.
- C. Each Council shall have authority to request the Board of Trustees to appoint sub-committees for any purpose within the functions of the Council. A member of the Council shall be designated as chairman of the sub-committee.
- D. Only active members of the Illinois State Medical Society (who are not voting members of the Board of Trustees) may be appointed to serve as chairmen or members of any council or committee. Voting members of the Board of Trustees may serve as advisory members to any council or committee.

Recommendations for membership on any committee may be submitted to the Board of Trustees by the House of Delegates, or in writing by any member of the Society.

A state committee which reviews the decisions of a similar committee of a component society may not have as a member one who currently serves on the same committee of a component society or district.

E. Each Council, sub-committee or special committee shall have authority to make rules to govern its procedures subject to:

(1) Specific requirements of the Constitution and Bylaws and the policies of the House of Delegates, and

(2) Approval of the Board of Trustees.

F. Each Council shall submit for adoption, a budget for the ensuing year, and the Board of Trustees shall determine the appropriation for each Council. Requests for additional funds must be approved by the Board before they are committed.

G. The president of the Society, the speaker of the House and the chairman of the Board shall be ex-officio members without vote of the various Councils, and may attend all committee meetings.

H. Each Council shall have members in sufficient quantity so that each sub-committee may be chaired by a different member.

I. Terms of office of members of the Councils shall not be more than three years, but may be terminated at any time at the discretion of the Board. No member of a Council shall serve more than three consecutive terms. Service of two or more years in an unexpired term shall be considered a full term.

J. Reports.

(1) Special committee reports shall be made by the chairman to the sub-committee from which he was appointed.

(2) Reports from sub-committees (which shall contain summaries of the report of special committees) shall be made by the chairman to the Council of which he is a member.

(3) Reports of Council activities shall include recommendations on reports and requests from sub-committees, and shall be made to the Board of Trustees by the chairman of the Council.

(4) The Chairman of the Council with the approval of the Board, may permit any member of a committee under the Council to clarify the report of that committee to the Board.

(5) The Chairman of any committee may request the Board of Trustees to allow him, or any member of his committee, to appear before the Board.

(6) All councils shall submit to the House of Delegates, written reports summarizing all actions, and may include recommendations for House consideration.

K. Vacancies on any committee may be filled at any time by the Board of Trustees. Com-

mittee membership may be enlarged or decreased or the committee may be discharged by the Board of Trustees.

L. Committee Meetings

The chairman of a committee, when he considers it expedient and with the consent of two thirds of the members of the committee, may conduct business or hold meetings by mail or by conference call, provided all members of the committee are given opportunity to participate, that minutes of the transactions are recorded, approved by members participating, and circulated among all committee members.

Section 4. Duties (Area of Concern)

A. The Medical-Legal Council shall be concerned in the areas of:

1. Liaison with the Illinois Bar Association
2. Liaison with courts, particularly where improper medical testimony is involved
3. Implementation of the Impartial Medical Testimony Rule
4. Legal aspects of medical practice other than in the area of mental health
5. Licensing and standards of practice
6. Quackery
7. Anatomical gifts and organ transplants

B. The Council on Legislation and Public Affairs shall be concerned in areas of:

1. Federal and state legislation—analysis and communication
2. Legislative liaison—both state and federal
3. Political education

C. The Council on Education and Manpower shall be concerned in the areas of:

1. Liaison with medical schools, curricula, etc.
2. Health manpower and training
3. Postgraduate education
4. Internships, residencies, etc.
5. Scientific assembly
6. Student loans
7. Liaison with Student American Medical Association
8. Continuing Medical Education

D. The Council on Economics and Peer Review shall be concerned in the areas of:

1. Relations with governmental purchase of care programs (Medicare, Medicaid, Vocational Rehabilitation, etc.)
2. Relations with prepayment, insurance and other third party plans
3. Fees and fee adjudication as promulgated by the Usual and Customary Fee Committee
4. Health care cost and utilization
5. Peer Review

E. Council on Environmental and Community Health shall be concerned in the areas of:

1. Governmental administrative regulation
—Departments of Health
2. Public Safety
3. Occupational Health
4. Child and School Health
5. Pollution
6. Nutrition

F. Council on Public Relations and Membership Services shall be concerned in the areas of:

1. Publicity and promotion
2. Media relations
3. Exhibits and public service programming
4. Religion and medicine
5. Illinois State Medical Society sponsored membership insurance programs
6. New member orientation and membership benefit explanation
7. Fifty Year Club

G. Council on Mental Health and Addiction shall be concerned in the areas of:

1. Facilities and services
2. Liaison with Department of Mental Health
3. Legal aspects of commitment, etc.
4. Narcotics and dangerous drugs
5. Alcoholism

H. Council on Social and Medical Services shall be concerned in the areas of:

1. Health care facilities and services
2. Emergency and disaster care
3. Liaison with other health professional and health oriented organizations
4. Relations with specialists not otherwise assigned
5. Problems of aging
6. Rural Health

Section 5. *Reference Committees*

Reference Committees shall be appointed by the speaker of the House of Delegates as outlined in Chapter X. REFERENCE COMMITTEES, and as provided therein.

PART 3. House of Delegates Committees.

SECTION I. *Committees*

A. *Appointment.* Immediately after the organization of the House of Delegates at each annual or special meeting, the speaker shall announce the appointment from among the members of the House, such committees as may be deemed expedient by the House of Delegates.

Each committee shall consist of five or more members unless otherwise provided, the chairman to be announced by the speaker. These committees shall serve during the meeting at which they are appointed.

B. *Duties of Reference Committees.* References, resolutions, measures and propositions presented to the House of Delegates shall be referred to the appropriate committee, which shall report to the House of Delegates before final action shall be taken.

A two-thirds affirmative vote of the House of Delegates shall be required to suspend this rule.

C. *Organization.* Each reference committee shall, as soon as possible after the adjournment of each session, or during the session if necessary, take up and consider such business as may have been referred to it, and shall report on same at the next session, or when called upon to do so.

D. *Reference Committees.* The following committees are hereby provided for:

A Committee on Credentials

A Committee on Rules and Order of Business

Tellers and Sergeants-at-Arms

A Committee on Changes in the Constitution and Bylaws

and such other reference committees as the speaker shall deem necessary to conduct the business of the House, or consider the reports of officers, trustees, executive administrator, the reports of committees pertaining to administrative activities, economics activities, scientific activities, public relations activities and legislative activities, as well as such resolutions, reports, and proposals as shall be brought before the House of Delegates.

E. *The Committee on Credentials* shall consider all questions regarding the registration and the credentials of the delegates. It shall pass out and receive the attendance slips for each session of the House of Delegates, and perform any other duties assigned.

F. *A Committee on Rules and Order of Business* shall consider all matters regarding rules governing action, method of procedure and order of business for the House of Delegates.

G. *The Tellers and Sergeants-at-Arms* shall

1. Serve the speaker of the House of Delegates
2. Distribute, collect and tally votes when a ballot is taken, or a numerical tally is required.
3. Certify those in attendance in closed or executive sessions of the House of Delegates.

H. *The Committee on Changes in Constitution and Bylaws* shall consider all proposed amendments to the Constitution and Bylaws.

The chairman of the Committee on Constitution and Bylaws, or his representative, shall serve in an advisory capacity to this reference committee and shall attend all sessions, including the executive sessions of the reference committee, to assist in the preparation of the report of the committee to the House of Delegates.

Section 2. *Ad hoc Committees*

- A. Ad hoc committees shall be appointed by the speaker of the House of Delegates to accomplish specific duties.
- B. Any member of the Society may be asked to serve.
- C. The terms of appointment shall be for the duration of the task, or until the committee shall be discharged.
- D. Ad hoc committees expected to serve for more than three years, shall be reorganized and given the status of a sub-committee or special committee under the appropriate Council and should be appointed by the Board of Trustees.
- E. Between meetings of the House of Delegates ad hoc committees shall report to the Board of Trustees keeping it informed of all current activities.

PART 4. *Committees*

Section 1. Board of Trustees Committees.

The Board shall form the following committees within itself:

- A. Executive Committee
- B. Finance Committee
- C. Policy Committee
- D. Ethical Relations Committee
- E. Committee on Committees
- F. Committee on Constitution and Bylaws
- G. Committee on Publications
- H. Advisory Committee to the Woman's Auxiliary, and

such others as deemed necessary.

Section 2. *Duties of the Committees.*

- A. *Executive Committee.* The Executive Committee shall consist of the president, the president-elect, the chairman of the Board, the chairman of the Finance Committee, the chairman of the Policy Committee, the secretary-treasurer, the trustee-at-large and the immediate past chairman of the Board, provided he is still a Trustee.

It may be given authority to act by the Board of Trustees.

In matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Policy Committees and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

- B. *Finance Committee.* The Finance Committee shall consist of the secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop for approval of the Board through the Executive Committee, a budget for the fiscal year. It shall supervise the financial transactions of the Society. It shall make recommenda-

tions to the Board for the control and investment of the funds of the Illinois State Medical Society.

The Medical Benevolence Committee shall be a subcommittee of the Finance Committee. It shall:

1. Examine applications to the Society for assistance to determine eligibility for assistance.
2. Keep the names of the beneficiaries confidential and known only to the committee.
3. Recommend to the Finance Committee the allotment for each recipient, and
4. If funds available become inadequate to meet disbursements, request the Board of Trustees to appropriate sufficient funds to support the program until the next budget appropriation.

- C. *Policy Committee.* The Policy Committee shall consist of three members of the Board appointed by the chairman. It shall continually review past and current proceedings of the House of Delegates to determine the established policies of the Illinois State Medical Society. It shall make recommendations for future policy by Board resolution to the House of Delegates.

- D. *The Ethical Relations Committee.* The Ethical Relations Committee shall be constituted and function as stipulated in CHAPTER XI. DISCIPLINE, Part 2 Illinois State Medical Society procedures.

- E. *The Committee on Committees.* The Committee on Committees shall consist of three members of the Board appointed by the chairman. It shall serve to review the purposes, activities and structure of any councils or committees at the request of the Board. The committee shall recommend such changes in existing councils or committees as required to maintain the efficient operation of the affairs of the Society.

The activities and reports of the Committee on Committees shall be reviewed by the Executive Committee and approved by the Board of Trustees.

- F. *The Committee on Constitution and Bylaws.* The Committee on Constitution and Bylaws shall:

1. Receive from individual members, county societies, committees, the Board of Trustees, and the House of Delegates, all suggestions and proposals for modification of the Constitution and Bylaws;
2. Prepare for the consideration of the House of Delegates, all changes in the Constitution and Bylaws; and
3. Maintain constant surveillance of both documents to keep them current, effective

and consistent with the policies of the House of Delegates.

G. *The Committee on Publications.* The Committee on Publications shall be composed of members of the Board of Trustees, and shall be responsible for the production of the *Illinois Medical Journal*.

It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the *Journal*. It shall supervise the editor in the selection and preparation of all copy, and it shall establish standards for the editorial content.

It shall establish advertising policies, rates, standards, and shall review all new accounts prior to acceptance, and shall approve reprint and circulation policies.

It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish the format, cover, type faces and general layout of the *Journal*.

It shall review, edit and supervise the publication of other materials as directed by the Board of Trustees.

H. *Advisory Committee to the Woman's Auxiliary.* The Advisory Committee to the Woman's Auxiliary shall consist of the president elect as chairman, the president and the chairman of the Board of Trustees.

The Committee shall provide advice and assistance to the president of the Woman's Auxiliary in her program for the year, and shall assist her in interpreting the activities of the Illinois State Medical Society.

CHAPTER X. COUNTY SOCIETIES

Section 1. All county societies now in affiliation with this Society, or those which may hereafter be organized in this state, which have adopted principles of organization in harmony with this Constitution and Bylaws, shall upon application to and approval by the Board of Trustees, receive a charter from and thereby become a component part of this Society, and members thereof shall become members of this Society and the American Medical Association.

Section 2. Charters shall be issued only on approval of the Board, and shall be signed by the president and the secretary of this Society.

The Board shall have authority to revoke the charter of any component society whose actions are in conflict with the letter and spirit of this Constitution and Bylaws.

Section 3. Only one component medical society shall be chartered in any county.

Section 4. Every registered physician holding the title of Doctor of Medicine or its equivalent, who either (1) resides in the jurisdiction of a component society, or (2) resides in a state other than Illinois but practices principally in the jurisdiction

of a component society and who is of good moral character and professional standing, shall be eligible to membership in that component society.

The component county society shall be the sole judge of the qualifications of its members, subject only to the stipulations contained in the Constitution and Bylaws.

Section 5. Any physician who has been disciplined by any action of a component society and believes he has not had a fair trial, shall have the right of appeal to the Board of Trustees.

Section 6. When a member in good standing in a component society changes his residence to another county in this state, such change of residence shall terminate his membership in such component society. (This ruling shall not apply to members in military service or in the service of the State or the United States government.)

Such member shall be entitled, upon his request, to a statement from his former secretary as to his standing. This statement of standing shall be issued without cost to the applicant.

He shall present this statement to the component society of the county to which he removes and it shall accompany his application for membership. The board of censors of the society receiving this application shall give this statement of prior standing due consideration before accepting or rejecting his application for membership.

Section 7. A physician living on or near a county line, or practicing partly or totally in an adjacent county, may hold his membership in the county most convenient for him, provided he submits written authorization to that society from the component society in whose jurisdiction he resides.

Section 8. The secretary of each component society shall keep a roster of its members, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary. In keeping such a roster the secretary shall note any changes in the personnel of the profession by death or by removal to or from the county. When requested, he shall furnish on blanks supplied him for the purpose, an official report containing such information for the secretary of this Society and likewise for the trustee of the district in which his county is situated.

Section 9. The secretary of each component society shall forward its roster of officers and members, and a list of delegates and alternate delegates to the secretary of this Society before the fifteenth of January each year.

Section 10. Any component society which fails to pay its assessment or make the annual report required on or before March fifteenth shall be held as suspended and none of its members shall be permitted to participate in any of the business or

proceedings of the Society or of the House of Delegates until such requirements have been met.

A member is in good standing unless otherwise disqualified, whose dues are paid on or before the first day of March of the current year. Immediately after the first of March, each delinquent member shall be notified that in consequence of non-payment of dues, his membership is delinquent. If dues remain unpaid as of June thirtieth of the current year, membership shall be dropped automatically. The member may be reinstated by paying all delinquent dues, provided, in the interim, he has not been guilty of conduct prejudicial to membership; but if two or more years have elapsed since he was a member in good standing, he must in addition, make application as a new member.

Section 11. The Constitution and Bylaws of the Illinois State Medical Society and of the American Medical Association, together with the Principles of Medical Ethics of the American Medical Association, shall be binding upon the members of the component societies.

CHAPTER XI. DISCIPLINE

PART 1. COMPONENT SOCIETY PROCEDURE

Section 1. *Local Ethical Relations Committee.* Each component society may have, either by appointment or election, an Ethical Relations Committee, whose duty it shall be to prosecute formal charges of unethical conduct. In the event that the county society does not have such a committee, the district Ethical Relations Committee shall function in its behalf.

All parties may have legal counsel present to advise and counsel them during the proceedings, but such counsel may not participate in the proceedings, and may be excluded from the hearing by the chairman or by vote of the committee.

The component society Ethical Relations Committee may establish reasonable rules of procedure, and they shall not be bound by the technical rules of evidence as the same pertain in courts of law. In all proceedings before such Ethical Relations Committees, the complainant, the accused and all witnesses before the committee shall be placed under oath.

The Committee shall evaluate acts by the standards established by the House of Delegates of the American Medical Association (specifically known as the Principles of Medical Ethics of the American Medical Association), and by such additional standards as shall be incorporated in the Constitution and Bylaws of the Illinois State Medical Society and/or the county medical society.

Section 2. *Offenses.* Any member of a component society shall be subject to censure, suspension or expulsion by such component society when

- A. He has been adjudged guilty by proper civil authorities of a criminal offense involving moral turpitude, or

B. He has been adjudged guilty by his component society in accordance with the procedural requirement of these bylaws:

- (1) of a gross misconduct as a physician, or
- (2) of a violation of the Constitution or Bylaws of his component society, or of the Illinois State Medical Society, or of the Principles of Medical Ethics promulgated from time to time by the American Medical Association.

Section 3. *Charges Initially Presented to the Illinois State Medical Society.* Original complaints received by the Illinois State Medical Society shall be referred directly to the secretary of the component society of which the accused is a member or to the district Ethical Relations Committee.

Section 4. *Principles of Justice.* The following principles of justice shall guide the Ethical Relations Committee in all disciplinary procedures.

A. An accused is presumed to be innocent until he has been proven guilty.

B. Formal charges before the Ethical Relations Committee of the component society or district Ethical Relations Committee must be presented under oath by the complaining party.

C. A trial shall be held by the committee within 30 days after the formal charges have been filed, unless continued by the chairman of the committee upon good cause shown.

D. The individual against whom formal charges have been filed shall be sent a copy of said charges by certified mail at least 10 days before the date set for the trial, together with a statement of the rights of the accused as follows:

- (1) to be represented by any member of the society as counsel and that he may have legal counsel present;
- (2) to cross-examine witnesses;
- (3) to offer in evidence any pertinent records or documents;
- (4) to object to any testimony or exhibits offered in evidence;
- (5) to address the trial body in his own behalf;
- (6) to be tried only on the specific charges filed;
- (7) to have stricken from the record any improper testimony or exhibits;
- (8) to appeal to the Board of Trustees of the Illinois State Medical Society.

Section 5. *Records.* A comprehensive stenographic record of the proceedings, together with all exhibits, must be kept for reference, and shall be available until final adjudication has been made.

In the event of an appeal being taken from the verdict of the local or district Ethical Relations Committee, the stenographic record shall be forwarded by certified mail to the Board of Trustees

of the ISMS at least ten days prior to the date the appeal is to be heard.

If the component society fails to provide the record on appeal, the Ethical Relations Committee of Illinois State Medical Society shall find the accused not guilty.

Section 6. Verdict. The committee, sitting as a trial body, shall find the accused either guilty or not guilty. If the verdict is guilty, the trial body shall recommend censure, suspension or expulsion.

The findings of the trial body must be presented to the component county society for approval or rejection. The accused must be notified by certified mail at least ten days before the date set for the meeting at which this action will be taken. If the findings of the trial body are against the accused the secretary of the component society shall acquaint the accused, by certified mail, with his right of appeal within thirty days to the Board of Trustees of the Illinois State Medical Society.

PART 2. ILLINOIS STATE MEDICAL SOCIETY PROCEDURES

Section 1. Illinois State Medical Society Ethical Relations Committee. The Board of Trustees shall appoint from its members, an Ethical Relations Committee to review decisions of the component society involving the interpretation of the Principles of Medical Ethics, violations of the Constitution and Bylaws of the Illinois State Medical Society or its component societies, and charges of misconduct of members of the Society.

Section 2. Appeals from Component Society Verdicts. Appeals received by the Illinois State Medical Society Board of Trustees shall be referred to the Ethical Relations Committee of the Board for review. (Appeals must be accompanied by a comprehensive stenographic record of the proceedings taken before the component county society together with all exhibits submitted in evidence. If the component county society fails to provide the record on appeal, the Ethical Relations Committee of Illinois State Medical Society shall find the accused "not guilty"). The committee shall notify the accused and the secretary of the component society by certified mail at least thirty days prior to the date set for the hearing of the appeal. The chairman of the committee shall preside over the hearing in accordance with the rules established by the Board of Trustees.

Section 3. Verdict. The Ethical Relations Committee of the Board of Trustees shall hear any new and pertinent evidence any interested party desires to present, and at the conclusion of the trial, the decision of the component society shall be affirmed, overruled or sent back to the component society for reconsideration.

Section 4. Notification and right of appeal. The secretary of the Society shall notify the defendant and the secretary of the component society

wherein the defendant holds membership, of the action of the Board. In the event of a decision against the accused he shall have the right to appeal the decision to the Judicial Council of the American Medical Association and the secretary of the State Society shall so notify the accused of this right.

CHAPTER XII PEER REVIEW ILLINOIS STATE MEDICAL

PART 1. COMPONENT SOCIETY PROCEDURE

Section 1. Local Peer Review Committee. Each component Society shall have, either by appointment or election, a Peer Review Committee whose duties it shall be to review all proper complaints and inquiries brought before it by physicians, patients, institutions, insurance carriers, or government agencies.

The district peer review committee shall function and operate on behalf of any county society which does not establish such a committee.

Section 2. The committee shall consist of a chairman and such members representing both general practice and various specialties as each individual county society shall determine. Such committee should have access to counsel from each of the various medical specialties. The component county society may establish reasonable rules of procedure but shall not be bound by the technical rules of evidence as the same pertains in courts of law. All proper complaints shall be reduced to writing and shall be signed by the individual making the complaint.

Section 3. Original complaints received by the Illinois State Medical Society shall be referred to the proper county society or to the district committee.

Section 4. The Peer Review Committee shall include the functions of the grievance committee, the prepayment plans and organizations committee, the mediation committee and any other committee having to do with investigations and review but shall not replace or supersede the ethical relations committee.

Section 5. The Peer Review Committee shall initiate consideration of all complaints and matters filed with it within 60 days from the date of filing and shall render an opinion within 30 days after the conclusion of the hearing. In the event the committee does not follow this procedure any party may appeal for relief to the proper district committee whose procedure shall be the same as is set forth herein for county societies.

Section 6. The Peer Review Committee shall have no disciplinary powers but instead, shall report its findings in writing to all parties involved. In the event the investigation and study of the committee results in a determination that there has been a violation of law or unethical conduct on the part of any physician, or a violation of the Constitution or Bylaws of his component society;

or of the Illinois State Medical Society, or of the Principles of Medical Ethics promulgated from time to time by the American Medical Association, the matter shall be referred in writing to the component society.

Section 7. In its study and deliberations the Peer Review Committee shall evaluate acts by the standards established by the House of Delegates of the American Medical Association (specifically known as the Principles of Medical Ethics of the American Medical Association), and by such additional standards as shall be incorporated in the Constitution and Bylaws of the Illinois State Medical Society and/or the county medical society.

Section 8. Any party to the proceedings considering himself aggrieved by the findings and recommendations of the committee shall have the right to appeal through the component society to the Illinois State Medical Society.

Section 9. In the event of an appeal to the Illinois State Medical Society, the county society shall send to the Illinois State Medical Society a copy of the complaint, the exhibits and the opinions of the county or district committee. Any appeal hereunder shall be filed with Illinois State Medical Society within 30 days after the final opinion of the county or district committee has been rendered.

PART II. ILLINOIS STATE MEDICAL SOCIETY PROCEDURES

Section 1. All appeals received by the Illinois State Medical Society shall be referred to the Council on Economics and Peer Review of the Board of Trustees, which shall review opinions of the county or district peer review committee. The Council shall have the power to counsel with and obtain information from medical specialists when appropriate.

Section 2. The Council upon receiving notice of an appeal shall set the matter for hearing within 30 days after the appeal has been filed and at such hearing shall review the record sent to it from the county society or district society, receive additional pertinent evidence any interested party desires to offer and render its conclusions and findings in writing, copies of which shall be mailed to all interested parties. The Peer Review Committee shall have no disciplinary powers but instead, shall report its findings to all parties involved. The conclusions and findings shall be advisory only.

Section 3. The Council on Economics and Peer Review of the Illinois State Medical Society shall include the functions of the grievance committee, the prepayment plans and organizations committee, the mediation committee and any other committee having to do with investigations and review but shall not replace or supersede the ethical relations committee.

Section 4. In the event the investigation and study of the Council results in a determination that there has been a violation of law or unethical conduct on the part of any physician, or a violation of the Constitution or Bylaws of his component society, or of the Illinois State Medical Society, or of the Principles of Medical Ethics promulgated from time to time by the American Medical Association, the matter shall be referred in writing back to the component society.

CHAPTER XIII. MISCELLANEOUS

Section 1. The fiscal year of this Society shall be from January 1 to December 31 inclusive.

Section 2. Robert's "Rules of Order, Revised," shall be the guide for all procedure when not in conflict with the Constitution and Bylaws.

CHAPTER XIV. AMENDMENTS

The House of Delegates may amend any article of these Bylaws by a two-thirds vote of the delegates present at any meeting, provided that such amendment shall not be acted upon before the day following that on which it was introduced.

Order of Business of the House of Delegates FIRST SESSION

1. Call to order.
2. Report of Committee on Credentials.
3. Roll Call.
4. Reading and approval of minutes of last meeting.
5. Appointment of Reference Committees.
6. Reports of Officers.
7. Reports of the Trustees, the Editor, etc.
8. Reports of Standing Committees.
9. Reports of Board Committees.
10. Reports of Special Committees.
11. Reading of Resolutions.
12. Unfinished Business.
13. New Business.
14. Recess.

LAST SESSION

1. Call to order
2. Report of Committee on Credentials
3. Roll Call
4. Reports of Reference Committees
5. Fixing of per capita tax for ensuing year
6. Selection of meeting place for next annual meeting. (Subject to the investigations of the Board.)
7. Unfinished business
8. Election of
 - (a) officers
 - (b) trustees
 - (c) delegates to the AMA
 - (d) alternate delegates to the AMA
9. Induction of President Elect into the office of President
10. New business
11. Adjournment (sine die)

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Policy Manual of the Illinois State Medical Society May 1970

"Policy statements shall be defined as guidelines for the management of the Illinois State Medical Society affairs, based upon prudence, sound judgment and experience."

"Rules and regulations may be prepared by the Board of Trustees or by committees, for use in the implementation of policy."

This manual shall be a guide for officers, trustees, committee chairmen and headquarters staff to the stand taken by the House of Delegates of the Illinois State Medical Society on all issues involving Society policy.

Its statements shall combine and reconcile the best expressions made on all phases of policy involving the House of Delegates, the Board of Trustees and the various committees.

All policy statements (except those involving the funds of the Society) shall have the approval of the House of Delegates, since the Constitution and Bylaws provide in ARTICLE V:

"The House of Delegates shall set the basic policy and philosophy of the Society."

All policy statements developed during the interval between meetings of the House shall be submitted at its next meeting for action. The House may:

- (1) approve, amend, or reject—
- (2) refer the statement to the Board for reconsideration and subsequent report—
- (3) remand the statement to the committee from which it came for further study and report.

Policy statements for the consideration of the House may appear as a portion of the annual report of the Policy Committee, or they may be contained in other reports to the House. The final statements for publication in this Policy Manual are to be prepared by the Policy Committee. Any member of the Illinois State Medical Society may submit a policy statement for consideration.

Temporary policy between meetings of the House is determined by the Board. Committees may request Board consideration at any time.

The Illinois State Medical Society shall support policy statements approved by the House of Delegates of the American Medical Association.

National policy is the prerogative of the national association. Until specific contrary action emanates from the AMA House of Delegates, the Board of Trustees and the officers of the ISMS shall consider all such policy as binding.

Policy action at the state level does not rescind official AMA rulings in Illinois, and the Society must recognize such policy until it has been changed at the national level.

The same "chain of command" should exist between the county medical society and the ISMS House of Delegates. Policy established at the State

Society level must prevail until majority action by the House of Delegates has rescinded or reversed the statements. This represents "majority rule" and must be followed closely to preserve the democratic processes.

Alcoholism

"Since alcoholism has been widely regarded as a disease for some time and because it is impossible to differentiate immediately between a chronic alcoholic and any other intoxicated person, the individual who is acutely ill from alcohol ingestion should be considered a health problem and therefore be adjudicated within the purview of the medical and other health professions."

Assessments

Compulsory assessments of members of hospital staffs for any purpose are unethical and improper.

Athletic Programs

Children of school age, through the 9th grade, should not participate in body contact sports.

Elementary school children develop better physically if activities are informal and not highly competitive.

Medical supervision of all athletic programs is essential.

Audits & Surveys

(Hospital, nursing homes, etc.)

Audits and surveys which impinge on personal privacy, patient care and local hospital trustee and medical decisions as to management should not be condoned.

Autonomy of County Medical Societies

No ruling of any county medical society shall conflict with the Principles of Medical Ethics of the American Medical Association, or with the Constitution and Bylaws of the Illinois State Medical Society.

In all other areas, the county society shall be autonomous.

Birth Certificates

Birth certificates should contain only such items as are pertinent to their function. Information recorded on birth certificates should not be provided to organizations or individuals for other than approved purposes.

Budgets—(see "Financial Policies")

Committee Appointments

The chairman of the Board of Trustees and the officers of ISMS shall give the trustees an opportunity to recommend physicians from their districts for appointment to various committees. Trustees shall receive the proposed list of committee appointments for their consideration and review prior to the meeting of the Board at which the final committee personnel is to be approved.

Elective committees should serve for uniform terms of office—preferably three years. These terms of office should be held on a staggered basis to provide continuity in the committee structure. Individual tenure on any committee should be limited to a maximum of nine years of continuous membership—whether elected or appointed.

Physicians appointed to an Illinois State Medical Society committee must be members in good standing of this Society.

Communicable Diseases

Physicians, especially those engaged in public health work, should enlighten the public concerning all regulations and measures for the prevention and control of communicable diseases. When an epidemic prevails, a physician shall continue his labors without regard to his own health.

Community Health Week

The medical profession shall provide the scientific leadership to focus attention on the health needs of the community and to encourage and assist in developing Community Health Week activities.

Conflict of Interest

When a case of conflict of interest arises and is self-evident, by the attitude shown by the individual concerned, it should be referred to the Executive Committee of the Board of Trustees of the ISMS for consideration.

Constitution and Bylaws

Final copy of any changes made by the House of Delegates in the Constitution and/or the Bylaws shall be prepared for publication by the Committee on Constitution and Bylaws, in consultation with legal counsel, making sure that the published changes reflect the thinking expressed by the action of the House.

Continuing Education

Continuing education shall be one of the basic purposes of the Illinois State Medical Society for scientific advancement, humanization of medicine, improvement of medical public relations, and development of cooperation and rapport with the public.

Co-operation with the American Medical Association

Actions of the AMA House of Delegates are binding upon its membership at all levels, county, state and national.

(Since all members of the Illinois State Medical Society are also members of the American Medical

Association, this is universally true in Illinois. The right to disagree, the right to protest, the right to become "the loyal opposition" is not questioned. However, until such time as the AMA House has reversed its decision, it is mandatory that the membership abide by the will of the majority.)

Cultists, Association with (Association with Osteopaths—see "O")

The Judicial Council of the American Medical Association has ruled that it is unethical to associate VOLUNTARILY with an individual who practices as a member of a "cult."

Disaster Control

Any disaster creates an obvious need for trained personnel to aid the sick and injured. Local medical societies should cooperate to provide medical self-help programs. County societies should provide training for their membership in the treatment of mass casualties, radiological casualties and in the organization, operation and maintenance of emergency hospitals.

Discrimination—(see "Freedom of Choice")

Dues, Recommendation of the Board to the House

The chairman of the Board of Trustees shall place the question of dues for the coming year on the agenda for consideration at the spring meeting of the Board.

Immediately following this meeting, written notice of the recommendation regarding dues for the next fiscal year, shall be mailed to all delegates and alternate delegates from the component societies, and also to all presidents and secretaries of county medical societies. This recommendation shall also be published in the *Illinois Medical Journal* as a part of the annual report of the Chairman of the Board.

Education, Primary and Secondary

Primary and secondary education is a community problem. In order to retain jurisdiction of these grade schools, finances should be raised by taxation at the local level.

Ethics

Cases involving ethics shall reach the state society level only by means of an appeal. As outlined in the Bylaws, the state society committee shall serve only as an appellate body to review such cases.

Examinations

All physical examinations should be performed in the physician's office. No examinations should be conducted on a group basis unless authorization has been given by the local county medical society in a single instance or for a specific purpose.

This general statement does not apply to the industrial or occupational health physician in his in-patient activities.

Facility Medical Boards (Physicians)

In all legislation which establishes boards for

the administration of medical facilities operated by governmental units, at least one-third of the board should be physicians licensed to practice medicine in all its branches.

Federal Funds

When a federal government assistance program is essential it should be conducted under the administration and control of local government. The Society does not favor any federal assistance program which removes administrative control from the state or local level.

Fee Schedules

No member or committee shall be permitted to approve a fee schedule for the Illinois State Medical Society until it has been submitted to and approved by the House of Delegates or the Board of Trustees.

Individuals covered by various fee schedules shall receive the best type medical care in all cases, and the physicians involved shall be remunerated according to the accepted fee schedule. Fees should be commensurate with services rendered.

Financial Policies

(also see "Assessments," etc.)

(1) The Finance Committee is to make budgetary recommendations to the Board of Trustees; however, such recommendations must be approved by the Board.

(2) The expenses of any duly elected delegate or alternate delegate attending the meetings of the House of Delegates of the American Medical Association shall not be assumed by the ISMS until he enters his official term of office set by the Constitution and Bylaws of the AMA.

(3) The expenses of any official representative of the ISMS attending any authorized meeting shall be determined by the Finance Committee and approved by the Board of Trustees.

(4) Any new project authorized by House action requiring the expenditure of funds must be accompanied by an estimate of the cost and suggested methods of providing the necessary funds.

(5) Budgets submitted to the House by the Board should provide for the ensuing fiscal year.

(6) In addition to fixed reserves, the development of a contingency reserve is desirable.

(7) All financial records shall be available at headquarters office, and may be examined by any member of the Society. A semi-annual summary of the financial statements of the Society shall be mailed to any county society secretary or delegate if requested. A projected budget for the next fiscal year shall be mailed to the members of the House of Delegates at least 30 days prior to the annual convention. These reports shall be in the format customarily used in ordinary corporate practice.

Freedom of Choice

The mutual right of physicians and patients to exercise freedom of choice in medical matters shall be maintained. This includes the right of the pa-

tient to choose the physician by whom he will be served, and the right of the physician (except in emergencies) to a corresponding freedom of choice. All members of the Illinois State Medical Society enjoy the same rights and privileges and are bound by the same obligations and standards of professional conduct.

Health Care—Ancillary Services

All segments of our population are entitled to and shall receive the best health care available. The physicians in Illinois are encouraged to cooperate in the implementation of any national program meeting with the general policy statements of the Society. (This shall be interpreted to include health aspects in nursing home care, use of recreational facilities, environmental health, public health, employment problems, etc., and any other area which involves the health of the residents of this State.)

Health Care Costs

The public should be educated concerning the difference between "health care costs" and "medical care costs." Members of the profession should cooperate with the various ancillary groups and should be able to explain the cost factors involved in total care.

Health Careers

All capable and worthy individuals interested in medicine as a career shall be encouraged and assisted by the Illinois State Medical Society. Those interested in paramedical fields shall be provided with all pertinent information.

Hospitals

Physicians should sponsor and assist in the development of all medical staff committees within the hospital.

The local medical profession should cooperate to achieve the accreditation of all eligible hospitals, and should encourage the stabilization or reduction of hospital costs in all areas where they have authority.

Hospital Assessments—See Assessments Hospital Committees (Dealing with physician-patient relationship)

All committees dealing with the review of physician-patient relationship in hospitals and nursing homes are urged not to release findings to any third parties except by subpoena or court order. Any reports issued by the committees involved should be submitted to the chief of staff for his disposition.

Hospital Records and Their Availability*

Hospital records are privileged information and the property of the patient, kept in trust by the hospital. They are not to be released except on a court order.

Upon receipt of a request signed by the patient, an abstract or a summary shall be provided when

**Under consideration for report by the Committee to Board and 1971 House.*

needed, to insurance companies, governmental agencies, consulting physicians, etc.

Hospital Staff Privileges

The medical staff of a hospital does not have the privilege or the right to make compulsory assessments of members of the medical staff for building funds, or to demand an audit of staff members' personal financial records as a requisite for staff appointments.

House of Delegates, Special Meetings of

When a special meeting of the House of Delegates is scheduled which may involve an increase in dues or a special assessment, the call for that meeting shall contain specific notification of that possibility.

Immunization Program

Illinois residents should be provided all types of immunization. Physicians are requested to provide this protection especially to all children, or to encourage the local public health agency to perform this function.

Every school should have a school health committee with at least one physician as a member. County advisory school health councils should assist in coordination.

Impartial Medical Testimony

The ends of justice are served when impartial medical witnesses are available to give testimony. The ISMS supports this concept and offers its assistance in the provision of impartial medical testimony.

Indigent, The Care of the

Personal medical care is primarily the responsibility of the individual. When he is unable to provide this care for himself, the responsibility should properly pass to his family, the community, the county, the state, and only when all these fail, to the federal government, and only in conjunction with the other levels of government in the order above.

The determination of medical needs should be made by a physician. The determination of eligibility should be made at the local level with local administration and control. The principle of freedom of choice should be preserved.

Individual Rights

Since this Society believes that a strong America is a free America, the rights of an individual, or a group of individuals, to openly express themselves cannot be condemned even if one is in complete disagreement, if the laws of the land are not violated. To support such condemnation would be inconsistent with this Society's basic philosophy.

Insurance Plans

Physicians are urged to cooperate with voluntary health insurance plans approved by the Illinois State Medical Society.

Fixed fee schedules should not be accepted. All fees should be based upon the usual and customary fee concept.

Insurance programs for the membership of the Illinois State Medical Society should be studied and implemented by the proper committee. Major medical and comprehensive hospital group coverage should be part of this insurance package.

Journal Publication

The Publications (Journal) Committee, with the approval of the Board of Trustees, has authority over the publication policy and the screening of all advertisers and advertising copy appearing in the *Illinois Medical Journal*.

Laboratories

All laboratories providing medical data should be under the direct supervision of a physician.

Lay Employees and Their Prerogatives

Policy is established by the House of Delegates.

Staff shall cooperate with officers and committee chairmen in setting up activities and in carrying out all necessary routine.

Staff also shall keep new officers and committee chairmen aware of policy statements, and assist them in the preparation of reports to the House of Delegates to:

- change existing policy
- establish new policy
- request House approval of committee projects and/or
- procedure involving policy.

Committees shall be informed of their right to set up operating rules and regulations.

Legal Counsel

The legal counsel of the Illinois State Medical Society shall concern himself with official inquiries from officers, trustees, committee chairmen and county medical societies. Such inquiries shall be channeled through the Executive Administrator.

Legislation

All matters pertaining to state or federal legislation shall be referred to the Legislative Committee for consideration and recommendation prior to Board of Trustees and/or House of Delegates action.

Matters pertaining to federal legislation shall be checked against recommendations or policies of the American Medical Association by the Council on Legislation of the Illinois State Medical Society prior to making a recommendation either to the Board of Trustees or to the House of Delegates.

Before any legislation is developed for presentation to the Illinois General Assembly, the proposed law shall be considered by the Council on Legislation, which shall work in close cooperation with any other Society committee involved. The instigating committee should determine the content of the law and the Legislative Council

primarily should consider relationship of the proposed legislation to the total legislative program.

Mailing List

The use of the mailing list of ISMS members must be approved by special action of the Board of Trustees.

Medical Care, Provision of

Medical care shall be provided regardless of the ability of the patient to pay. Physicians shall not refuse to render needed emergency care to any patient.

Medical Representation in Government Planning

In health programs financed by government funding in an Illinois community, there shall be representation at the highest policy level by an official representative of the State Society and the appropriate county medical society involved. Remuneration for services in above programs shall follow the policies of the Illinois State Medical Society.

Membership in Paramedical and Service Organizations

Membership in Chambers of Commerce (city, state and national) is to be encouraged. This policy extends to the individual physician as well as to the component societies.

Membership in the Illinois Association of the Professions is encouraged. Medicine should be well represented among these allied professional groups and the growth and development of the Association is of concern to ISMS economically, politically and scientifically.

The Society recommends that physicians affiliate with service clubs, local political action groups and participate to the fullest extent possible in affairs affecting the health and welfare of the residents of Illinois.

Membership of Osteopathic Physicians in ISMS

Osteopathic physicians who meet all qualifications for membership, base their practice on the same scientific principles as those adhered to by members of the AMA, and are licensed to practice medicine in all its branches in Illinois, may be accepted as active members by the county medical societies throughout the state, and be accorded all privileges of full membership at the county and state levels and be so reported to the American Medical Association for acceptance at that level.

Mental Health

Mental health planning should be implemented at the community level. County medical societies should be kept aware of their responsibilities to assist in developing improved mental health facilities.

A physician licensed to practice medicine in all its branches should be required to certify the discharge of any patient from a psychiatric institution.

Shortage of Nurses

A severe shortage of graduate nurses continues to imperil the provision of quality patient care. The ISMS supports all forms of qualified nursing education and urges that all such schools be encouraged to remain in operation.

Occupational Health

Occupational health is an essential ingredient of employee welfare. The adoption and development of health programs in industry should be encouraged.

Occupational health will be advanced through the utilization of all physicians involved in industrial work.

Osteopaths, Association with

Voluntary professional associations with a Doctor of Osteopathy are not deemed unethical if the Doctor of Osteopathy bases his practice on the same scientific principles as those adhered to by members of the American Medical Association and if he is licensed to practice medicine and surgery in all of its branches in Illinois.

Placement Service

Before the Physicians' Placement Service recommends that a town in Illinois be listed as needing a physician, it shall be established that the need actually exists; that the community can support a physician; that certain physical assets (office—home—schools, etc.) are available for the physician and his family.

The qualifications of the physician also shall be ascertained prior to furnishing him with the list of available areas in Illinois needing a physician.

Policy Statements

Policy statements shall be defined as guide lines for the management of the Illinois State Medical Society affairs, based upon prudence, sound judgment and experience.

Rules and regulations may be prepared by the Board of Trustees or by committees, for use in the implementation of policy.

Polls, Opinion

The vote of the House of Delegates shall express the opinion of the majority of the Illinois State Medical Society membership. Since delegates are the duly elected representatives of their county medical societies and their voting reflects the thinking of their constituents, a majority opinion HAS BEEN expressed, and a membership poll becomes unnecessary except under very exceptional conditions.

Prepayment Plans and Organizations

It is not within the province of ISMS to act in other than an advisory capacity when working with a "third party plan," and its best efforts should be directed toward supplying guidance, education and communications between the membership and the prepayment plans and organizations involved.

The principle of free enterprise as exemplified

by private insurance companies and the "Blue" plans is to be endorsed.

Press

All county medical societies should cooperate with the local press. The public should be provided with prompt and accurate information in all health fields; the source of this information should be the medical profession.

County medical societies should provide information at the local level; the State Society is responsible for press releases involving State Society officers or any official statements of the Society appearing in the press.

A code of ethics applicable to medicine and the fourth estate should be developed. (That used in the Decatur area has been given national recognition by the AMA.)

Publication of Research Data

In releasing research material for publication in the *Illinois Medical Journal*, or any other media, extreme care should be exercised. The welfare and privacy of the patient, the professional reputation of the physician should be of primary concern.

If any question arises, consultation with the Board of Trustees is suggested. All such inquiries should be addressed to its chairman.

Public Affairs

No officer or member of the Board of Trustees should be permitted (during his term of office) to allow his name as an officer or a member of the Board to be used in lists endorsing candidates for public office. Naturally his right to this privilege as a private individual is not affected.

Public Aid

The "chain of command and procedure" in handling problems arising in the field of public aid shall be from the county to the state society advisory committee; then the state advisory committee shall assume the responsibility of making the medical program work and cooperating with the Illinois Department of Public Aid to maintain the best type medical care for the recipients of state aid.

The fees paid by the state/federal programs to physicians shall be based upon the usual and customary fee concept.

An extensive program of education should be conducted for the recipients of public aid. This should include the intelligent handling of all monies provided.

Rehabilitation of all recipients should be of paramount concern.

Public Health Departments

"Public Health is the art and science of maintaining, protecting and improving the health of the people through organized community efforts, including contributions by voluntary health associations, medical societies and other health-oriented groups.

"Full-time modern local Health Departments

adequately financed and staffed at the county or multiple county level are highly desirable and if available, would be capable of providing these services to the people throughout the state. It is of paramount importance that such departments should be established where none now exist and that county medical societies, as well as physicians, should give their wholehearted support."

Public Safety

Motor vehicle operators should be licensed on the basis of the applicant's physical and mental capacity to operate such a vehicle safely.

Rebates

1) "In conformity with the AMA Principles of Ethics, rebates of any nature to any member, county or regional medical society, are unethical." This statement on rebates was developed as a result of a letter regarding collection services. It read in part:

"It is our policy to remit to a participating association the sum of 10 per cent of the gross book sales to its members in addition to 10 per cent of the gross commissions received from collections. A report and accompanying payment is submitted monthly from our office."

Reference Committee Appointments

Whenever possible at least two members shall be retained on all reference committees for the following year in order to effect continuity of experience.

Reference Service

Physician reference service shall be the responsibility of the county medical society. When any such request is received at the state society office or by any officer of the ISMS, it shall immediately be referred to the secretary of the county medical society involved.

Rehabilitation

All physical rehabilitation activities should be prescribed by a physician and the treatment carried out under the supervision of a physician.

Medical societies should render assistance to public and private agencies regarding rehabilitation facilities to be used and in the selection of patients for these services.

Insurance carriers should be encouraged to include rehabilitation services in their contracts.

Relative Value

The Relative Value Study is not a fee schedule and is to be used for information only.

No co-efficient shall be established at the state level. The data contained in the study may be used by the ISMS, its committees or by any county medical society.

The study should be revised at appropriate intervals upon the recommendation of the committee with the approval of the Board of Trustees.

Upon request, copies may be furnished third party purveyors of health care services.

Specialty Society Representation on ISMS Councils

For the improvement of communication and the discussion of problems of mutual interest and concern, closer liaison between specialty societies of medicine and the councils of the Board of Trustees is desirable. Representatives to serve in this capacity may be nominated by the specialty society, approved by the Board of Trustees of ISMS, and designated as consultants to the council without vote, in compliance with the Bylaws.

Stationery, Use of Official

No officer, trustee, committee chairman or staff director is to use the official stationery of the Illinois State Medical Society for personal statements of any nature. This shall pertain especially to the endorsement of any candidate for public office.

Surveys

The Illinois State Medical Society endorses the

principle of mass surveys and encourages the use of this method whenever it meets with the approval of the local county medical society.

Any new state program involving more than one county society should be submitted to the Board of Trustees for initial approval.

Veterans Administration

It is our belief that a Veterans Administration hospital should admit only those patients with service-connected disabilities, except in those instances where the veteran is financially unable to pay for his medical care and hospital services, as shown by a means test.

Woman's Auxiliary

Projects in which the Auxiliary participates shall be approved by the local county medical society.

Requests for cooperation between the Auxiliary and the Illinois State Medical Society should be channeled through the Advisory Committee provided by the Board of Trustees.

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Vice Speaker of the ISMS House of Delegates

Andrew J. Brislen
(Except when presiding as Speaker)

A complete listing of delegates and alternates to the ISMS will
appear with the convention program

AMA Delegation

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Elected May 21, 1968

(to serve from Jan. 1, 1969 to Dec. 31, 1970)

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Elected May 21, 1969

(to serve from Jan. 1, 1970 to Dec. 31, 1971)

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HAROLD A. SOFIELD

715 Lake Street, Oak Park 60301

PHILIP G. THOMSEN

13826 Lincoln, Dolton 60419

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1800 Third Avenue, Rock Island 61201

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Elected May 20, 1970

(to serve from Jan. 1, 1971 to Dec. 31, 1972)

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Francis W. Young

H. Close Hesseltine

Carl E. Clark

Joseph R. Mallory

Burtis E. Montgomery, 37 South Main Street,
Harrisburg 62946

Walter C. Bornemeier, 4665 Peterson Avenue,
Chicago 60646

Delegate—AMA Section

Henry A. Holle, 1350 N. Lake Shore Drive,
Chicago 60610

ALTERNATE DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Elected May 21, 1968

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1000 Lake Shore Plaza, Chicago 60611

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5906 West North Avenue, Chicago 60639

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620 N. Main St., Carrollton 62016

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Elected May 21, 1969

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Kankakee 60901

George F. Lull, 2440 Lakeview Ave., Chicago
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CHICAGO MEDICAL SOCIETY See page 356.

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 515 Lincoln Hwy., Rochelle 61068
 Members: 23—District No. 1

PEORIA COUNTY

President: Ward H. Eastman
 427 1st National Bank Bldg., Peoria 61602
 Secretary: Dean R. Bordeaux
 427 1st National Bank Bldg., Peoria 61602
 Executive Secretary: David W. Meister
 427 1st National Bank Bldg., Peoria 61602
 Members: 232—District No. 4

PERRY COUNTY

President: Byford I. Hall
 701 N. Washington St., DuQuoin 62832
 Secretary: Billy R. Fulk
 P.O. Box 245, DuQuoin 62832
 Members: 16—District No. 10

PIATT COUNTY

President: George Green
 340 N. State St., Monticello 61856
 Secretary: Joseph Allman
 121 N. State St., Monticello 61856
 Members: 6—District No. 7

PIKE COUNTY

President: A. C. Schewe
 203 N. Madison, Pittsfield 62363
 Secretary: B. J. Rodriguez
 880 Bainbridge St., Barry 62312
 Members: 9—District No. 6

PULASKI COUNTY

President: A. L. Robinson
 Box 277, Mounds 62964
 Secretary: Marvin F. Powers
 107-A S. Oak St., Mounds 62964
 Members: 2—District No. 10

RANDOLPH COUNTY

President: Ralph Kuhlman
 824 S. Locust St., Red Bud 62278
 Secretary: C. S. Schlageter
 101 N. Market, Sparta 62286
 Members: 18—District No. 10

RICHLAND COUNTY

President: C. Harrison
 600 East Main St., Olney 62450
 Secretary: T. Martin
 Weber Medical Clinic, Olney 62450
 Members: 24—District No. 8

ROCK ISLAND COUNTY

President: Billie Shevick
 729 3rd Ave., Moline 61265
 Secretary: Newell T. Braatelen
 Moline Public Hospital, Moline 61201
 Executive Secretary: James A. Koch
 612 Kahl Building, Davenport, Iowa 52801
 Members: 146—District No. 4

ST. CLAIR COUNTY

President: Stuart W. Mauch
 301 W. Lincoln St., Suite 106, Belleville 62221
 Secretary: Peter Soto
 St. Elizabeth's Hospital, Belleville 62221
 Executive Director: Ed Belz
 4825 West Main St., Belleville 62223
 Members: 188—District No. 10

SALINE-POPE-HARDIN COUNTY

President: John E. Choisser
 Box C, Harrisburg 62946
 Secretary: Warren R. Dammers
 Box 281, Harrisburg 62946
 Members: 26—District No. 9

SANGAMON COUNTY

President: Howard Penning
 1315 N. 5th St., Springfield 62702
 Secretary: John M. Holland
 700 N. 7th St., Springfield 62702
 Executive Secretary: L. R. Brosi
 2100 Lindsay Road, Springfield 62704
 Members: 215—District No. 5

SCHUYLER COUNTY

President: R. R. Dohner
 103 W. Washington, Rushville 62681
 Secretary: Henry C. Zingher
 Rushville Clinic, Rushville 62681
 Members: 4—District No. 4

SHELBY COUNTY

President: Harvey H. Pettry
 407 West Main St., Shelbyville 62565
 Secretary: Smith D. Taylor
 520 Penns Ave., Windsor 61957
 Members: 8—District No. 7

STEPHENSON COUNTY

President: William Katel
 222 West Exchange St., Freeport 61032
 Secretary: R. Samuel Hoover
 Box 573, Freeport 61032
 Members: 37—District No. 1

TAZEWELL COUNTY

President: Erik Maran
 427 1st National Bank Bldg., Peoria 61602
 Secretary: Robert M. Wright
 427 1st National Bank Bldg., Peoria 61602
 Executive Secretary: David W. Meister
 427 1st National Bank Bldg., Peoria 61602
 Members: 46—District No. 5

UNION COUNTY

President: William H. Whiting
 Box 410, Anna 62906
 Secretary: William H. Whiting
 410 Anna 62906
 Members: 7—District No. 10

VERMILION COUNTY

President: A. R. Matteson
 101 W. North St., Danville 61832
 Secretary: L. W. Tanner
 7 N. Virginia, Danville 61832
 Members: 88—District No. 8

WABASH COUNTY

President: T. R. Young
 512 Market St., Mount Carmel 62863
 Secretary: C. J. Johns
 114 West 5th St., Mt. Carmel 62863
 Members: 7—District No. 9

WARREN COUNTY

President: Joseph Simmons
 Kirkwood 61447
 Secretary: Glenn W. Chamberlin
 219 East Euclid St., Monmouth 61462
 Members: 11—District No. 4

WASHINGTON COUNTY

President: Charles W. Longwell
 111 South Washington, Nashville 62263
 Secretary: Jerry L. Beguelin
 Box 197, Irvington 62848
 Members: 4—District No. 10

WAYNE COUNTY

President: C. J. Jannings
 101 East Center, Fairfield 62837
 Secretary: S. W. Konarski
 101 East Center Fairfield 62837
 Members: 7—District No. 9

WHITE COUNTY

President: William H. Courtneage
 Carmi Medical Center, Carmi 62821
 Secretary: Phillip D. Boren
 South Plum St., Carmi 62821
 Members: 7—District No. 9

WHITESIDE COUNTY

President: Darroll J. Erickson
 Sterling—Rock Falls Clinic
 101 East Miller Road, Sterling 61081
 Secretary: John F. Hubbard
 110 Dixon Ave., Rock Falls 61071
 Members: 41—District No. 2

WILL-GRUNDY COUNTY

President: Ernest F. Kreutzer
 719 Catherine St., Joliet 60435
 Secretary: Frederick C. Bauer
 600 Walnut St., Joliet 60432
 Executive Secretary: Don M. Kline
 58 N. Chicago St., Room 201, Joliet 60431
 Members: 188—District No. 11

WILLIAMSON COUNTY

President: Roger Hendricks
 121 N. 13th St., Herrin 62948
 Secretary: H. V. Fine
 110 N. Division St., Carterville 62918
 Members: 30—District No. 9

WINNEBAGO COUNTY

President: John P. McHugh
 2623 Edgemont St., Rockford 61103
 Secretary: Donald P. Feeney
 2300 N. Rockton Ave., Rockford 61101
 Executive Adm.: Donald A. Westbrook
 310 N. Wyman St., Rockford 61101
 Members: 277—District No. 1

WOODFORD COUNTY

President: Joseph C. Phifer
 203 S. Main St., Eureka 61530
 Secretary: James Riley
 109 S. Major St., Eureka 61530
 Members: 10—District No. 2

**NO ORGANIZED
COUNTY SOCIETY**

Brown
 Johnson
 Marshall
 Putnam

JOINT COUNTY SOCIETIES

Coles-Cumberland
 Henry-Stark
 Jefferson-Hamilton
 Jersey-Calhoun
 Morgan-Scott
 Saline-Pope-Hardin
 Will-Grundy

CHICAGO MEDICAL SOCIETY

President: William E. Adams
55 E. Erie Street, Chicago 60611
President-Elect: Andrew J. Brislen
6060 S. Drexel Blvd., Chicago 60637
Secretary: Charles P. McCartney
950 E. 59th Street, Chicago 60637
Treasurer: H. Kenneth Scatiff
310 S. Michigan Ave., Chicago 60604
Executive Vice-President: George F. Lull
310 S. Michigan Ave., Chicago 60604
Executive Director: Robert J. Lindley
310 S. Michigan Ave., Chicago 60604
Members: 6,441—District No. 3

BRANCH OFFICERS

Aux Plaines Branch

President: Martin W. Green
7579 West Lake St., River Forest 60305
Secretary-Treasurer: Robert C. Muehrcke
518 N. Austin Blvd., Oak Park 60303

Calumet Branch

President: Thomas S. Patricoski
11110 S. Sawyer Ave. 60655
Secretary: Elizabeth Hemmons
11049 S. Fairfield Ave. 60655

Douglas Park Branch

President: Ben E. Wagner
6729 Stanley Ave., Berwyn 60402
Secretary-Treasurer: Kent F. Borkovec
3340 S. Oak Park Ave., Berwyn 60402

Englewood Branch

President: George A. DeJong
4391 West 95th St., Evergreen Pk. 60642
Secretary-Treasurer: Thomas Peter Driscoll
2800 W. 87th St. 60652

North Suburban Branch

President: Lawrence J. Lawson, Jr.
636 Church St., Evanston 60204
Secretary-Treasurer: Stanley E. Huff
636 Church St., Evanston 60204

Irving Park Suburban Branch

President: Lawrence L. Hirsch
836 Wellington 60657
Secretary: Vincent C. Sarley
811 W. Wellington Ave. 60614

Jackson Park Branch

President: Albert B. Lorincz
5841 S. Maryland Ave. 60637
Secretary-Treasurer: Matthew W. Kobak
5555 S. Everett Ave. 60637

North Shore Branch

President: Rocco V. Lobraico
4833 W. Peterson Ave. 60646
Secretary: William O. Ackley
2439 W. Foster Ave. 60625

North Side Branch

President: I. Pat Bronstein
30 N. Michigan Ave. 60602
Secretary-Treasurer: Joseph C. Sherrick
303 E. Superior St. 60611

Northwest Branch

President: E. J. Kotanyi
1174 N. Milwaukee Ave. 60622
Secretary-Treasurer: Alfonso Diaz
1802 S. Racine Ave. 60608

South Chicago Branch

President: Thomas S. Bernat
624 West 31st St. 60616
Secretary-Treasurer: Anthony Cesare
9204 Commercial Ave. 60617

South Side Branch

President: Kermit T. Mehlinger
4901 S. Drexel Blvd. 60615
Secretary: Otto J. Keller
5825 S. Dorchester Ave. 60637

Southern Cook County Branch

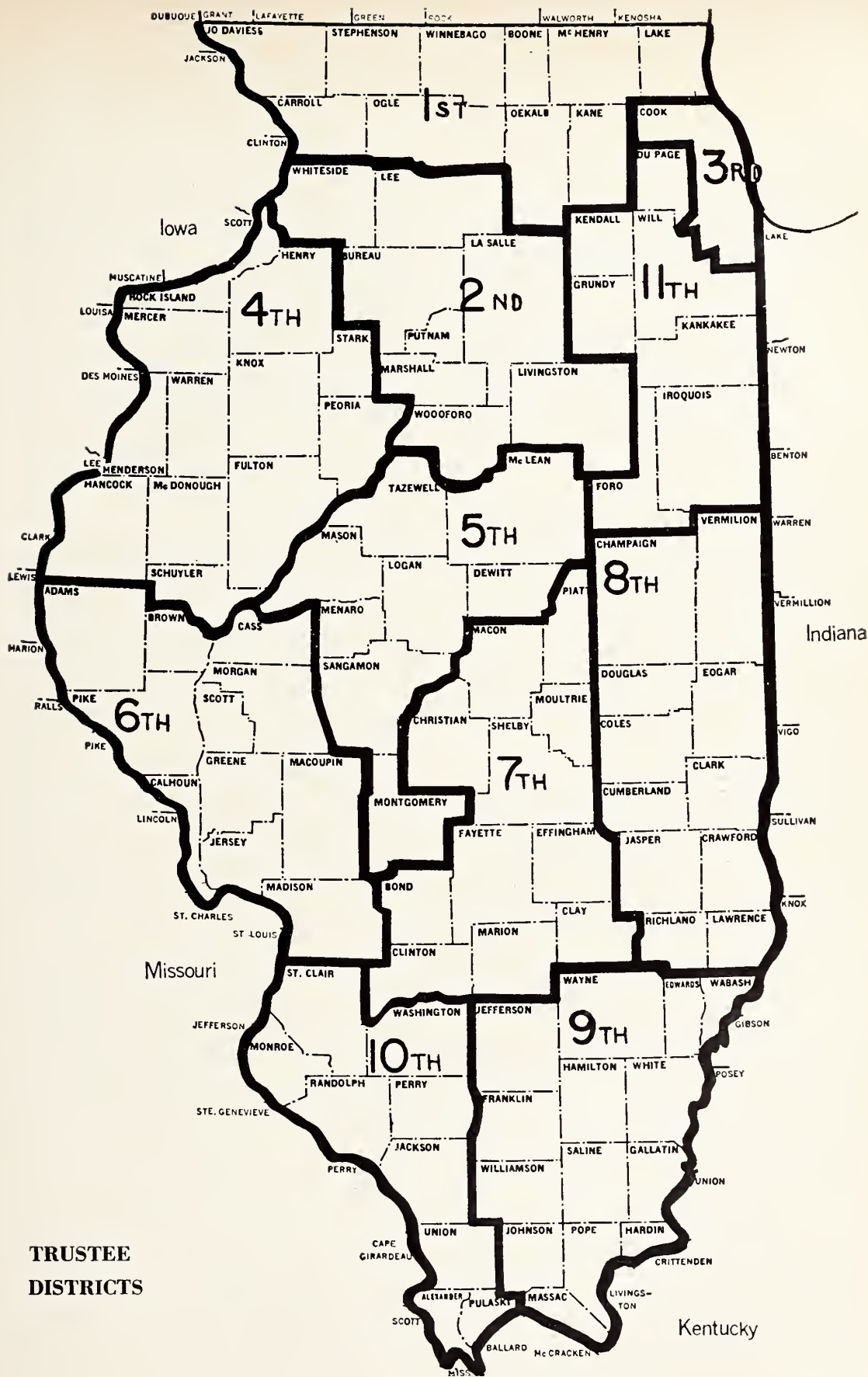
President: John E. Driscoll
18109 Dixie Hwy., Homewood 60430
Secretary-Treasurer: Paul P. David
159 E. 144th St., Riverdale 60627

Stock Yards Branch

President: Maurice M. Hoeltgen
1836 West 87th St. 60620
Secretary-Treasurer: Edwin J. Lukaszewski
1213 W. 51st St. 60609

West Side Branch

President: Anna A. Marcus
5852 West North Ave. 60639
Secretary-Treasurer: William J. Tansey
414 S. Oak Park Ave., Oak Park 60303



**TRUSTEE
DISTRICTS**

TRUSTEE DISTRICT COMMITTEES

First District

Joseph L. Bordenave, Geneva, *Trustee*
 Counties of Boone, Carroll, DeKalb, Jo Daviess,
 Kane, Lake, McHenry, Ogle, Stephenson, Win-
 nebago

ETHICAL RELATIONS COMMITTEE TERM EXPIRES
 John H. Steinkamp, Belvidere, *Chairman*1972
 Gerald Liesen, St. Charles1973
 John W. Ovitz Jr., Sycamore1971
 E. J. McKinney, Rockford1972

PEER REVIEW COMMITTEE

Russell Zack, Rochelle, *Chairman*1973
 Kenneth L. Morris, Stockton, *Co-Chairman* 1971
 R. Gregory Green, Rockford1972
 M. Mijanovich, Marengo1971
 Walter J. Reedy, Waukegan1972
 Jerald A. Bowman, Rockford1971
 John E. Madden, Freeport1973
 Rodney Nelson, Geneva1972
 Erwin A. Schilling, Rockford1972
 R. E. Whitsitt, Rockford1972
 Delbert O. Williams, Jr., Stockton1971

Second District

William A. McNichols, Jr., Dixon, *Trustee*
 Counties of Bureau, LaSalle, Lee, Livingston,
 Marshall, Putnam, Whiteside, Woodford

ETHICAL RELATIONS COMMITTEE TERM EXPIRES

K. Dexter Nelson, Princeton, *Chairman*1971
 Ralph Bailey, Ottawa1972
 Tim Sullivan, Sterling1973

PEER REVIEW COMMITTEE

K. M. Nelson, Princeton, *Chairman*1972
 M. D. Burnstine, Sterling, *Co-Chairman*1973
 James B. Aplington, LaSalle1973
 LaMonte Ballard, Sterling1973
 Francis J. Brennan, Utica1973
 Silvio Davito, Spring Valley1973
 Bernard J. Doyle, LaSalle1973
 Donald Edwards, Dixon1973
 William Ehling, Streator1971
 Julius Kolis, Dixon1973
 P. Lymberopoulos, Dixon1973
 Edward Murphy, Dixon1971
 Rowland Musick, Mendota1973
 Joseph Phifer, Eureka1972
 Goodwin Taraason, Peru1973
 Louis Tarsinos, Princeton1973

Philip Terry, Kewanee1973
 Theodore W. Wagenknecht, Streator1973

Third District

Frederick E. Weiss, Chicago, *Trustee*
 James B. Hartney, Oak Park, *Trustee*
 Frank J. Jirka, Jr. River Forest, *Trustee*
 Fredric D. Lake, Evanston, *Trustee*
 William M. Lees, Lincolnwood, *Trustee*
 Warren W. Young, Chicago, *Trustee*

No district committees are appointed.

Fourth District

Fred Z. White, Chillicothe, *Trustee*
 Counties of Fulton, Hancock, Henderson, Henry,
 Knox, McDonough, Mercer, Peoria, Rock Is-
 land, Schuyler, Stark, Warren

ETHICAL RELATIONS COMMITTEE TERM EXPIRES

Richard Icenogle, Roseville, *Chairman*1971
 John Bowman, Abingdon1973
 George Burke, Rock Island1972

PEER REVIEW COMMITTEE

Russell Jensen, Monmouth, *Chairman*1973
 William O. McQuiston, Peoria, *Co-Chairman* 1972
 F. A. Christensen, Peoria1972
 William G. Neilson, Kewanee1972
 James C. Parsons, Geneseo1973
 Donald Dexter, Macomb1971

Fifth District

A. Edward Livingston, Bloomington, *Trustee*
 Counties of DeWitt, Logan, McLean, Mason,
 Menard, Montgomery, Sangamon, Tazewell

ETHICAL RELATIONS COMMITTEE TERM EXPIRES

William W. Curtis, Springfield, *Chairman*1971
 Arthur Conklin, Bloomington1973
 Jack Means, Mason City1972

PEER REVIEW COMMITTEE

James Borgerson, Mt. Pulaski, *Chairman*1971
 Robert Price, Blomington, *Co-Chairman*1971
 Ross Billiter, Litchfield1973
 George Irwin, Bloomington1973
 John G. Meyer, Springfield1972
 Alton J. Morris, Springfield1973
 Robert B. Perry, Lincoln1973
 Robert Schaefer, Petersburg1972
 James Weiner, Pekin1973

Sixth District

Mather Pfeifferberger, Alton, *Trustee*
Counties of Adams, Brown, Calhoun, Cass,
Green, Jersey, Macoupin, Madison, Morgan,
Pike, Scott

ETHICAL RELATIONS COMMITTEE TERM EXPIRES

Joseph J. Grandone, Gillespie, *Chairman*1971
Bernard Baalman, Hardin1972
W. W. Bowers, Granite City1973
Edward K. DuVivier, Alton1971

PEER REVIEW COMMITTEE

Richard Cooper, Quincy, *Chairman*1971
James Reid, Greenfield, *Co-Chairman*1971
E. C. Bone, Jacksonville1973
Jude A. Caselton, Carrollton1972
Bruno DeSulis, Beardstown1971
Robert R. Hartman, Jacksonville1972
Robert C. Murphy, Quincy1973
Frank B. Norbury, Jacksonville1972
Meyer Shulman, Pittsfield1971

Seventh District

Arthur F. Goodyear, Decatur, *Trustee*
Counties of Bond, Christian, Clay, Clinton,
Effingham, Fayette, Macon, Marion, Moultrie,
Piatt, Shelby

ETHICAL RELATIONS COMMITTEE TERM EXPIRES

Carl Sandburg, Decatur, *Chairman*1973
Max Hirschfelder, Centralia1971
E. H. Rames, Vandalia1972

PEER REVIEW COMMITTEE

Richard Larson, Shelbyville, *Chairman*1971
Boyd McCracken, Greenville1971
Stanley Moore, Vandalia1973
Walter P. Plassman, Centralia1973
William Sargeant, Effingham1973

Eighth District

Eugene P. Johnson, Casey, *Trustee*
Counties of Champaign, Clark, Coles, Crawford,
Cumberland, Douglas, Edgar, Jasper, Lawrence,
Richland, Vermilion

ETHICAL RELATIONS COMMITTEE TERM EXPIRES

Mack W. Hollowell, Charleston, *Chairman*1971
James H. Pass, Olney1972
Alan M. Taylor, Danville1973

PEER REVIEW COMMITTEE

A. R. Brandenberger, Danville, *Chairman*1971
James W. Landis, Olney, *Co-Chairman*1971
Eugene Johnson, Casey1972
Gorgon Sprague, Paris1973
E. A. Kendall, Mattoon1973
George T. Mitchell, Marshall1972

Ninth District

Charles K. Wells, Mt. Vernon, *Trustee*
Counties of Edwards, Franklin, Gallatin, Hamil-
ton, Hardin, Jefferson, Johnson, Massac, Pope,
Saline, Wabash, Wayne, White, Williamson

ETHICAL RELATIONS COMMITTEE TERM EXPIRES

Warren D. Tuttle, Harrisburg, *Chairman*1972
Philip Boren, Carmi1971
Andrew Krajec, West Salem1973

PEER REVIEW COMMITTEE

C. J. Jannings, III, Fairfield, *Chairman*1973
Denton Farrell, Eldorado, *Co-Chairman*1971
John Duffey, Rosiclare1971
Herbert Fine, Carterville1972
Ernest Lowenstein, Mt. Carmel1973
A. Watson Miller, Herrin1972

Tenth District

Willard C. Scrivner, E. St. Louis, *Trustee*
Counties of Alexander, Jackson, Monroe, Perry,
Pulaski, Randolph, St. Clair, Union,
Washington

ETHICAL RELATIONS COMMITTEE TERM EXPIRES

A. L. Robinson, Mounds, *Chairman*1973
Harold McCann, East St. Louis1971
William Borgsmiller, Murphysboro1972

PEER REVIEW COMMITTEE

Joseph A. Petrazio, Murphysboro, *Chairman*1973
George Cutridge, DuQuoin, *Co-Chairman*1973
Charles Baldree, Belleville1973
Eli Borken, Carbondale1973
R. W. Jost, Waterloo1972
B. Kinsman, DuQuoin1973
R. E. Schettler, Red Bud1971
William H. Walton, Belleville1972
William H. Whiting, Anna1971
Charles L. Yarbrough, Cairo1973

Eleventh District

Joseph R. O'Donnell, Glenn Ellyn, *Trustee*
Counties of DuPage, Ford, Grundy, Iroquois,
Kankakee, Kendall, Will

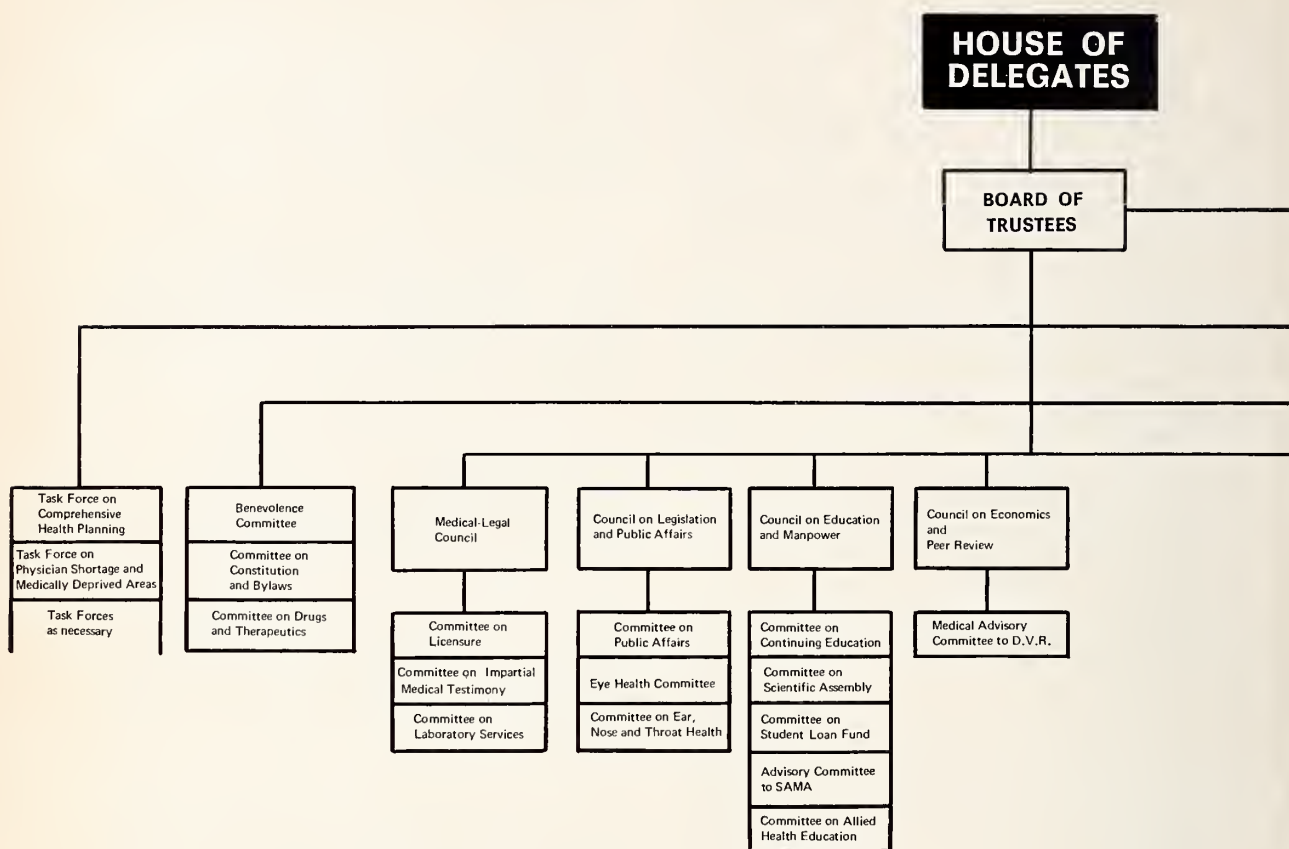
ETHICAL RELATIONS COMMITTEE TERM EXPIRES

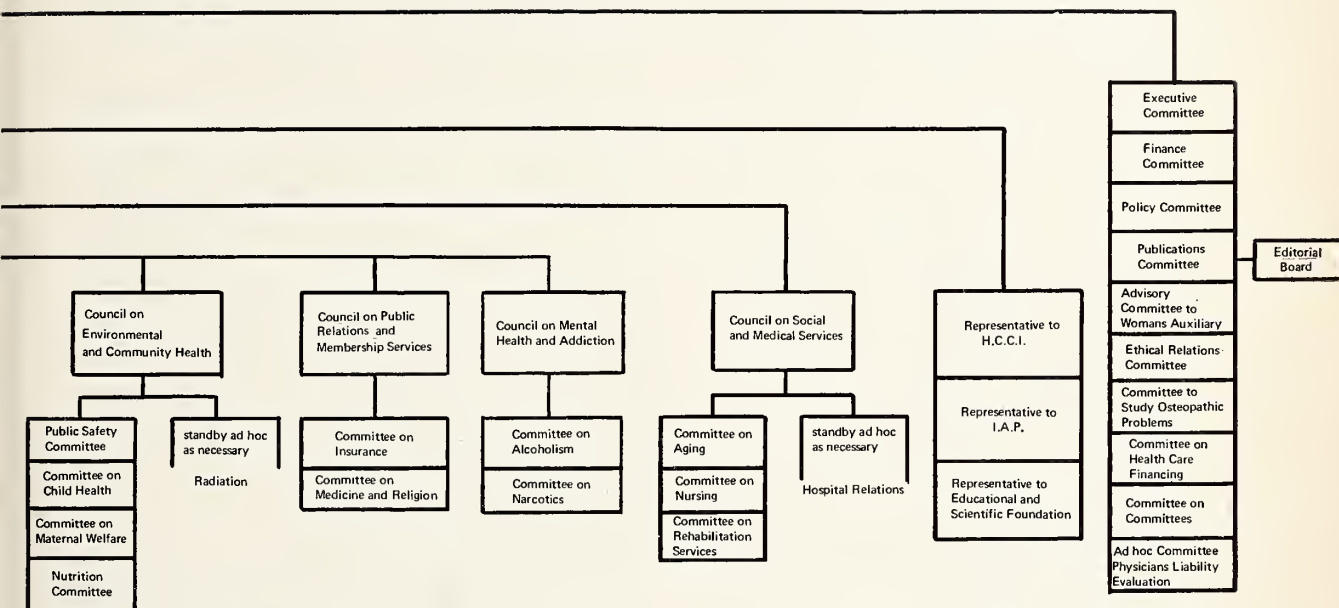
James Ryan, Kankakee, *Chairman*1972
John Bowden, Joliet1973
Lawrence D. Lee, Manhattan1973

PEER REVIEW COMMITTEE

James Campbell, Wheaton, *Chairman*1972
James E. Dailey, Watseka1972
James Lambert, Joliet1973
Guy Pandola, Joliet1972
William C. Perkins, West Chicago1973
Julius Schweitzer, Hinsdale1971
Victor Smith, Newark1971

ISMS Organization





Councils of the Illinois State Medical Society

Committees of the Illinois State Medical Society are appointed by the Chairman of the Board of Trustees subject to approval of the Board of Trustees, and are assigned to one of eight councils. The councils are similarly appointed and are composed of committee chairmen and such other members as are necessary to accomplish the purposes of the council. Some committees are composed of members of the Board of Trustees and are designated Board Committees. Some committees may report directly to the board and are not assigned to a council. Task Forces are established to address a particular problem or concern which crosses areas of responsibility of the several councils. The task forces report directly to the board, as do representatives to various other agencies.

COUNCIL ON ECONOMICS & PEER REVIEW

Glen E. Tomlinson, *Chairman*
4 Lincoln Professional Park, Lincoln 62626
Fred A. Tworoger, *Vice-Chairman*
4753 Broadway, Chicago 60640
Rex O. McMorris
619 N.E. Glen Oak Ave., Peoria 61603
Charles E. Baldree, Jr.
26 E. Washington, Belleville 62220
Eli Borkon
Carbondale Clinic, Carbondale 62901
Stanley Bobowski
407 S. Fourth, Champaign 61820
Edward DuVivier
1900 Brown St., Alton 62002
John L. Eaton
4204-35th Ave., Moline 61265
Maynard Shapiro
7531 Stony Island, Chicago 60649
John P. Marty
1315 N. 5th St., Springfield 62702
Don Michels
533 W. North, Elmhurst 60126
Earl Walker
18 Peachtree Place, Harrisburg 62946
R. Gregory Green
1355 Charles St., Rockford 61108
Robert Muehrcke
518 N. Austin, Oak Park 60302
Hilliard M. Shair
1101 Main St., Quincy 62301
Reuben Gaines
30 N. Michigan Ave., Chicago 60602
Clinton L. Lindo
110 East 79th St., Chicago 60619
Robert Becker
58 N. Chicago, Joliet 60431
Burton Jacobson
3425 W. Peterson, Chicago 60645

CONSULTANTS

Fred Z. White
723 N. Second Street, Chillicothe 61523
Joseph R. O'Donnell
444 Park, Glen Ellyn 60137
Frank J. Jirka, Jr.
1507 Keystone Ave., River Forest 60305
SAMA REPRESENTATIVES:
Joyce Root
2801 S. King Dr., Apt. 912 Chicago 60616
James Whitehouse
15 W. Delaware Place, Chicago 60610
STAFF: Joseph Lotharius

Committee:

Advisory to the Division of Vocational Rehabilitation

Responsibilities and Purposes:

The Council on Economics and Peer Review shall:

- 1) Serve as the appellate body for peer review in the state to consider cases appealed from local committees involving the quality and quantity of medical care;
- 2) Provide a channel of communication between ISMS and government intermediaries, the health insurance industry, Blue Cross-Blue Shield Plans and similar organizations in matters of mutual concern;
- 3) Initiate, explore and bring to the attention of the Board of Trustees suggested policies and philosophies relating to medical service in Illinois;
- 4) Advise the staff in socio-economic issues and further the health and welfare of the public by seeking continuous improvement of medical service in Illinois;
- 5) Advise the Illinois Division of Vocational Rehabilitation and other state health agencies on matters pertaining to fees and the quality of medical services

COUNCIL ON EDUCATION AND MANPOWER

Jack Gibbs, *Chairman*
24-26 Main Street, Canton 61520
Herschel Browns
4600 N. Ravenswood Ave., Chicago 60640
T. Howard Clarke
999 Lake Shore Dr., Chicago 60611
Robert T. Fox
2136 Robin Crest Lane, Glenview 60025
George O. Dohrmann
3000 Logan Blvd., Chicago 60647
Lawrence L. Hirsch
834 West Wellington, Chicago 60657
Richard Magraw
Box 6998, Chicago 60680
Herman J. Nebel
629 Vogel Place, East St. Louis 62201
R. Charles Oldfield
40 S. Clay, Hinsdale 60521
James M. Schless
3249 S. Oak Park Ave., Berwyn 60402
Donald Stehr
102 E. Market, Havana 62644

CONSULTANTS:

L. T. Fruin
5 Citizen's Square, Normal 61761
William M. Lees
6518 N. Nokomis, Lincolnwood 60646
Fred Z. White
723 N. 2nd Street, Chillicothe 61523

MEDICAL SCHOOL REPRESENTATIVES:

Chicago Medical School
James Shaffer
2020 W. Ogden Ave, Chicago 60612
Stritch School of Medicine, Loyola University
William B. Rich
2160 S. 1st, Maywood 60153
Northwestern University Medical School
Edward S. Petersen
303 E. Chicago Ave., Chicago 60611
Rush Medical School
Robert Carton
1725 W. Harrison, Chicago 60612
University of Chicago

Richard Landau
950 E. 59th Street, Chicago 60637
University of Illinois
Richard Magraw
Box 6998, Chicago 60680
Southern Illinois University School of Medicine
Richard H. Moy
715 E. Carpenter St., Springfield 62702
SAMA REPRESENTATIVES:
John Logan
547 Marengo, Forest Park 60130
Mike Youssi
709 South Ada, Chicago 60607
STAFF: Perry L. Smithers

Responsibilities and Purposes:

The Council on Education and Manpower shall (1) study and evaluate all phases of medical education including the development of programs approved by the House of Delegates for the provision of a continuing supply of well-qualified physicians; (2) study and evaluate education relating to the health professions and services important to medicine, including the development of

programs approved by the House of Delegates for the provision of a continuing supply of well qualified personnel in these fields; (3) carry to the deans of the medical schools recommendations from the viewpoint of the practicing physician; (4) study, evaluate and criticize the postgraduate programs of ISMS and other organizations; (5) be available to advise and cooperate with the Department of Registration and Education of the State of Illinois; (6) serve as liaison between ISMS and the Student American Medical Association; (7) administer the Student Loan Fund program which is operated jointly by ISMS and the Illinois Agricultural Association; and (8) organize, coordinate and administer the scientific sessions of the ISMS subject to the regulations outlined in the By-laws, especially those in Chapter II, Annual Convention, Section 3, Scientific Meetings.

Committees

Advisory to SAMA
Allied Health Education
Continuing Education
Scientific Assembly
Student Loan Fund

COUNCIL ON ENVIRONMENTAL AND COMMUNITY HEALTH

Edward A. Piszczek, *Chairman*
6410 N. Leona, Chicago 60646
Howard C. Burkhead, *Co-Chairman*
2650 Ridge Ave., Evanston 60201
Arthur M. Barnett
143 N. Washington St., Wheaton 60187
James P. Campbell
322 N. Blanchard St., Wheaton 60187
Eugene F. Diamond
11055 S. St. Louis Ave., Chicago 60655
Robert Hartman
1515 A West Walnut St., Jacksonville 62650
John S. Hyde
603 Forest Ave., Oak Park 60302
Ralph S. Kunstadter
664 N. Michigan, Chicago 60611
Arthur E. Sulek
Region VI, Ill. Dept. of Public Health
4302 N. Main St.
Rockford 61103
SAMA REPRESENTATIVES:
Alan Lee Ansel
9157 S. Chappel, Chicago 60617
Robert Pollnow
2326 W. 48th St., Chicago 60609
CONSULTANT:
Warren W. Young
10816 Parnell Ave., Chicago 60628
AUXILIARY REPRESENTATIVE:
Mrs. Robert Hartman
1040 W. College, Jacksonville 62650
STAFF: Perry L. Smithers

Responsibilities and Purposes:

The Council on Environmental & Community Health shall cooperate with the Illinois Department of Public Health in certain specific areas. Its responsibilities shall include the maintenance, protection and improvement of the health of the people of Illinois through organized community efforts.

It shall serve as a source of information on chronic illness and communicable diseases and cooperate with institutions and voluntary health agencies in disseminating such information.

It is responsible for medicine's interest in the relationship of man to his surroundings, particularly air, water and soil pollution; health problems related to population growth, urbanization and technological development bearing on the ecology of man.

The council also shall be concerned with diseases and problems associated with occupational and industrial health, cooperate with the Council on Occupational Health of AMA, Industrial Medical Association and similar state agencies and to recommend to the State of Illinois Workman's Compensation Board medical procedures designed to assist the board in the evaluation of claims.

Committees:

Public Safety
Child Health
Maternal Welfare
Nutrition
Radiation *ad hoc*

COUNCIL ON LEGISLATION & PUBLIC AFFAIRS

Alfred J. Faber, 2100 Swainwood Drive, Glenview 60025
Frank Holman, Christian Welfare Hospital 1509 Illinois Ave., East St. Louis 62201

Richard Allyn, 709 Myers Building, Springfield 62701
John W. Ovitz, Jr., 204 West Elm Street, Sycamore 60178
Frank J. Kresca, 208 West Green, Champaign 61822
Eugene J. Scherba, 13826 Lincoln Avenue, Dolton 60419
James Ryan, 1309 E. Court Street, Kankakee 60901
Warren Tuttle, 203 N. Vine Street, Harrisburg 62946
John J. Ballenger, 723 Elm St., Winnetka

CONSULTANTS:

C. J. Jannings, III, 1001 Center Street, Fairfield 62837
Fredric D. Lake, 1041 Michigan Avenue, Evanston 60202
Frank J. Jirka, Jr., 1507 Keystone Avenue, River Forest 60305

William M. Lees, 6518 Nekomis, Lincolnwood 60646
James B. Hartney, 410 Lake Street, Oak Park 60302

AUXILIARY REPRESENTATIVE:

Mrs. Alan Taylor, 1607 N. Vermillion, Danville 61832

SAMA REPRESENTATIVE:

Mark Brakke, 710 North Lake Shore Dr., Chicago 60611
School (N.W. Med Sch) 6710 North Sheridan Road
Apt. 301, Chicago Home

STAFF: Timothy D. Selleck

Responsibilities and Purposes

The Council on Legislation and Public Affairs shall:

1. Keep the Society and its members aware of all state and federal legislation and laws affecting the health of citizens of Illinois and the practice of medicine in Illinois.
2. Promulgate legislation to improve the health care of citizens of Illinois and the practice of medicine in Illinois.
3. Cooperate with the AMA in similar programs.
4. Develop programs to educate the public and the Illinois State Medical Society membership in the privileges and responsibilities of citizenship.

Committees:

Public Affairs
Eye Health
Ear, Nose & Throat Health Committee

MEDICAL-LEGAL COUNCIL

Clinton L. Compere, *Chairman*, 737 North Michigan Avenue, Chicago 60611

Ross Hutchison, 126 East Ninth, Gibson City 60936
George Alvary, 1110 North Green St., McHenry 60050
David T. Petty, 30 North Michigan Blvd., Chicago 60602
Vincent Sarley, 811 W. Wellington, Chicago 60657
Herman Wing, 400 East Randolph St., Chicago 60601
Joseph Sherrick, 1128 Jeffrey Court, West, Northbrook
Leonard C. Arnold, 1700 W. Lawrence Avenue, Chicago 60640

CONSULTANTS:

Wm. A. McNichols, Jr., 101 West 1st, Dixon 61021
Fredric Lake, 2520 North Lakeview Avenue 60614
William Lees, 6518 N. Nokomis, Lincolnwood 60646
Joseph L. Bordenave, 1665 South St., Geneva 60134

SAMA REPRESENTATIVES:

Gregory Keller, 825 South Lathrop, Forest Park
Edward Quebbeman, 1926 W. Harrison, Chicago

STAFF: H. Michael Wild

Responsibilities and Purposes

The functions of the Medical Legal Council are to 1) maintain liaison with the Bar Association; 2) supervise the activities of the Council's three committees; and 3) to educate the members of the profession in medico-legal affairs.

The Council members include the Chairmen of the Licensure, IMT, and Laboratory Services Committees, to facilitate cooperation and coordination of activities. The Council further cooperates fully with the AMA for purposes of coordinating programming.

Committees:

Impartial Medical Testimony
Laboratory Services
Licensure

COUNCIL ON MENTAL HEALTH AND ADDICTION

Marshall A. Falk, *Chairman*
4700 N. Clarendon, Chicago 60640
John H. McMahan, *Vice-Chairman*
8601 W. Main St., Belleville 62223
Nathaniel S. Apter
111 N. Wabash, Chicago 60602
Milton C. Baumann
725 S. 2nd St., Springfield 62704
Mark Fields
716 S. Milwaukee, Libertyville 60648
Irving Frank
135 S. Sacramento, Sycamore 60178
Abraham Gelperin
835 S. Wolcott, Chicago 60612
Richard Graff
204 Julie Drive, Kankakee 60901
Walter P. Plassman
Box 552, Centralia 62801

Billie H. Shevick
729-3rd Ave., Moline 61265
Joseph H. Skom
707 N. Fairbanks Ct., Chicago 60611
Alex Spadoni
2112 W. Jefferson, Joliet 60435
W. David Steed
1011 Lake St., Oak Park 60301
Donovan Wright
135 S. Kenilworth Ave., Elmhurst 60126
SAMA REPRESENTATIVES:
Richard Jacobs
1720 N. Hudson, Chicago 60614
David Shapiro
633 S. Laflin, Chicago 60607
CONSULTANT:
A. E. Livingston
219 N. Main St., Bloomington 61701

AUXILIARY REPRESENTATIVE:

Mrs. Michael Parenti

1039 Lathrop Ave., River Forest 60305

STAFF: Perry L. Smithers

Responsibilities and Purposes:

The responsibilities of this council are as follows: It shall serve as a source of information on mental health matters for the ISMS. It shall evaluate available information and make recommendations to the Board of Trustees for the position the ISMS should take on issues in this area. It shall also cooperate with institutions and

voluntary health agencies in disseminating information on mental health subjects to the profession and the public. It shall be on the alert for misleading or fallacious programs and information which need correcting for the protection of the public.

The Council shall be especially concerned with the problems of alcoholism and drug abuse.

Committees:

Alcoholism

Narcotics

COUNCIL ON PUBLIC RELATIONS AND MEMBERSHIP SERVICES

Matthew B. Eisele, *Chairman*

Kil Mar Medical Building, Suite 209

8601 W. Main St., Belleville 62223

Lee F. Winkler

850 S. 4th, Springfield 62703

M. Douglas Hursh

1492 N. Main St., Wheaton 60187

Anna Marcus

5852 W. North Ave., Chicago 60639

Clifton Reeder

734 N. Merrill Ave., Park Ridge 60068

Charles J. Weigel

7579 Lake St., River Forest 60305

CONSULTANTS

Paul W. Sunderland

214 N. Sangamon St., Gibson City 60936

L. T. Fruin

5 Citizen's Square, Normal 61761

Fredric D. Lake

1041 Michigan Ave., Evanston 60202

SAMA REPRESENTATIVES:

Henry Covelli

414 N. Taylor, Apt. 3H, Oak Park 60302

Roger Rodgers

5540 Winthrop, Apt. #3, Chicago 60640

AUXILIARY REPRESENTATIVE:

Mrs. Leslie Lindeen

801 Stevens Ave., Sycamore 60178

STAFF: Jim Slawny

Responsibilities and Purposes:

The Council on Public Relations and Membership Services shall plan and execute programs designed to enhance the relationship between the media, clergy, general public and medical profession. Included shall be health education and socio-economic programs believed to be in the best interest of the profession as well as the general public. The Council shall be responsible for all insurance programs sponsored by ISMS on behalf of the membership. It shall also be responsible for all other membership services.

Committees:

Medicine & Religion

Insurance

COUNCIL ON SOCIAL & MEDICAL SERVICES

Thomas R. Harwood, *Chairman*

333 E. Huron, Chicago 60611

William A. Hutchison

4753 N. Broadway, Chicago 60640

Kenneth A. Hurst

157 S. Lincoln, Aurora 60505

Joel D. Rosen

3950 N. Lake Shore Drive, Chicago 60613

Paul Theobald

1210 Towanda Plaza, Bloomington 61801

Thomas T. Tourlentes

1801 N. Seminary St., Galesburg 61401

CONSULTANT:

L. T. Fruin

5 Citizen's Square, Normal 61761

SAMA REPRESENTATIVES:

Ned Bartlet

423 W. Belden, Chicago 60657

STAFF: Robert Westerbeck

Responsibilities and Purposes:

The Council on Social and Medical Services shall initiate and implement programs on health and socio-economic problems of the aging and shall maintain liaison with other health professionals and health-oriented groups related to the fields of aging, nursing, hospital services, rehabilitation services and government health care programs. Special attention should be given to quality of care given by health care facilities such as hospitals, nursing homes and extended care facilities.

Committees:

Aging

Nursing

Rehabilitation Services

Hospital Relations *ad hoc*

Committees

The following committees have been appointed for the year 1970-1971. Each committee is assigned to a council for reporting purposes, except those that are composed entirely of trustees, or which, for reasons of efficiency and control, report directly to the Board of Trustees.

COMMITTEE ON AGING (Council on Social & Medical Services)

Thomas T. Tourlentes, *Chairman*

1801 N. Seminary St., Galesburg 61401

W. W. Bowers

1820 Delmar Avenue, Granite City 62040

James R. Durham

601-5th Ave., Mendota 61342

Bertram Moss

Chicago Medical School

1648 S. Albany, Chicago 60623

Clyde Rulison

Box 38, Roberts 60932

CONSULTANT:

A. E. Livingston

219 N. Main, Bloomington 61701

AUXILIARY REPRESENTATIVE:

Mrs. Maurice Woll

159 S. 9th, East Alton 62024

STAFF: Robert Westerbeck

Responsibilities and Purposes:

The Committee on Aging shall consider matters related to the broad field of aging, including socio-economic as well as medical services. The committee shall maintain liaison with other agencies having a similar interest, including the American Medical Association's Committee on Aging.

COMMITTEE ON ALCOHOLISM (Council on Mental Health and Addiction)

Abraham Gelperin, *Chairman*

835 South Wolcott, Chicago 60612

Charles L. Anderson

120 N. Oak Street, Hinsdale 60521

David Stinson

2126 Jonquil Place, Rockford 61103

J. M. Stoker

172 Schiller St., Elmhurst 60126

John C. Troxel

222 N. Dearborn, Chicago 60601

William H. Wehrmacher

670 N. Michigan Ave., Chicago 60611

James West

2400 W. 95th St., Chicago 60642

SAMA REPRESENTATIVE:

Mark Larsen

710 N. Lake Shore Drive, Chicago 60611

STAFF: Perry L. Smithers

Responsibilities and Purposes

The Committee on Alcoholism serves as an ISMS resource on alcoholism and evaluates information and makes recommendations to the Board of Trustees for the position ISMS should take on issues in this area. It cooperates with institutions, industry, government and health agencies in disseminating information on the causes, prevention, diagnosis, and treatment of alcoholism to the medical profession and the public.

COMMITTEE ON ALLIED HEALTH EDUCATION (Council on Education and Manpower)

Richard M. Magraw, *Chairman*

Box 6998, Chicago 60680

Lawrence L. Hirsch, *Vice-Chairman*

834 West Wellington, Chicago 60657

James D. Eggers, Jr.

2160 1st Ave., Maywood 60153

Burton M. Krimmer

5736 W. North Ave., Chicago 60639

Robert B. Lynn

209 Henry St., Alton 62002

Donald E. Rager

530 N. E. Glen Oak Ave., Peoria 61603

Paul G. Theobald

1210 Towanda Plaza, Bloomington 61701

Sheldon S. Waldstein

801 Skokie Blvd., Northbrook 60062

SAMA REPRESENTATIVE:

Kevin Paulsen

818 S. Wolcott, Chicago 60612

CONSULTANTS:

Walter C. Bornemeier

4655 Peterson Ave., Chicago 60646

Donald C. Frey

410 N. Michigan, Chicago 60611

James B. Hartney

410 Lake St., Oak Park 60302

Eugene P. Johnson

22 W. Main St., Casey 62420

Israel Light

2020 W. Ogden, Chicago 60612

STAFF: Perry L. Smithers

Responsibilities and Purposes

As a means to alleviate the effects of a physician shortage that exists in virtually all parts of Illinois, it has been suggested that allied health personnel be educated and trained to perform certain medical procedures heretofore done only by physicians. This committee should be concerned with the specific types of medical procedures which could be done readily by trained non-physicians and what education and training is needed to qualify

such individuals as "assistant physicians." The committee necessarily will concern itself with the legality of this activity under the Illinois Medical Practice Act, the implications of licensure and relations with the Illinois Department of Registration and Education, and liaison with medical schools and other educational institutions established for training of the personnel involved.

COMMITTEE ON BENEVOLENCE Sub-Committee of Finance Committee (Board of Trustees)

Keith H. Frankhauser, *Chairman*
Avon 61415

Allison L. Burdick, Sr.

5906 West North Avenue, Chicago 60639

Leo P. A. Sweeney

10400 South Western Avenue, Chicago 60643

AUXILIARY REPRESENTATIVE:

Mrs. Lloyd Teter

335 Country Club Drive, Pekin 61554

STAFF: Frances C. Zimmer

Responsibilities and Purposes:

The Medical Benevolence Committee shall be a sub-

committee of the Finance Committee and shall:

1) Examine applications to the Society for assistance to determine eligibility for assistance.

2) Keep the names of the beneficiaries confidential and known only to the committee.

3) Recommend to the Finance Committee the allotment for each recipient, and

4) If funds available become inadequate to meet disbursements, request the Board of Trustees to appropriate sufficient funds to support the program until the next budget appropriation.

COMMITTEE ON CHILD HEALTH (Council on Environmental and Community Health)

Ralph H. Kunstadter, *Chairman*

664 N. Michigan Ave., Chicago 60611

Irving Abrams

2800 Lake Shore Dr., Chicago 60657

Samuel Adler

913 Ottawa Dr., Dixon 61021

Richard E. Dukes

Carle Clinic, Urbana 61801

W. W. Fullerton

101 N. Market St., Sparta 62286

Edmond R. Hess

1737 W. Howard St., Chicago 60626

Eduard Jung

13826 Lincoln Ave., Dolton 60419

Franklin Munsey

1429 Myott Ave., Rockford 61101

Kenneth S. Nolan

172 Schiller, Elmhurst 60216

T. A. Palus

101 Orchard Terrace, Lombard 60148

Norman T. Welford

656-58th St., Hinsdale 60521

SAMA REPRESENTATIVE:

Patricia Dix

2910 Logan Blvd., Chicago 60647

CONSULTANTS:

Edward Lis

840 S. Wood, Chicago 60612

J. Keller Mack

922 S. 4th St., Springfield 62702

AUXILIARY REPRESENTATIVE:

Mrs. Alton Morris

1616 Leland Ave., Springfield 62704

STAFF: Perry L. Smithers

Responsibilities and Purposes

The committee shall serve as a source of information on matters pertaining to child health. It shall evaluate available information and make recommendations to the Board of Trustees for the position the ISMS should take on issues in this area and cooperate with institutions and voluntary health agencies in disseminating information pertinent to general child health. It shall be on the alert for misleading or fallacious programs and information which need correction for the protection of the public. It shall conduct educational programs for public enlightenment for the encouragement and the establishment of school health councils; it shall strive for increased services for exceptional children. It shall conduct in cooperation with the Maternal Welfare Committee research on neonatal mortality through the state; and shall seek the formulation and adoption of uniform school health records.

COMMITTEE ON COMMITTEES
(Board of Trustees)

Warren W. Young, *Chairman*
10816 Parnell Avenue, Chicago 60628
William A. McNichols, Jr.
101 West 1st Street, Dixon 61021
A. Edward Livingston
219 North Main Street, Bloomington 61701
STAFF: Frances C. Zimmer

Responsibilities and Purposes:

The Committee on Committees shall consist of three members of the Board appointed by the chairman. It shall serve to review the purposes, activities and structure of any councils or committees at the request of the Board. The committee shall recommend such changes in existing councils or committees as required to maintain the efficient operation of the affairs of the Society.

The activities and reports of the Committee on Committees shall be reviewed by the Executive Committee and approved by the Board of Trustees.

COMMITTEE ON CONSTITUTION & BYLAWS
(Board of Trustees)

Charles K. Wells, *Chairman*
117 North 10th Street, Mt. Vernon 62864
Fredric D. Lake, *Co-Chairman*
1041 Michigan Avenue, Evanston 60202
Arthur F. Goodyear
142 East Prairie Street, Decatur 62523
CONSULTANT:
Frank M. Pfeifer
STAFF: Frances C. Zimmer

Responsibilities and Purposes:

The Committee on Constitution & Bylaws shall:

- 1) Receive from individual members, county societies, committees, the Board of Trustees and the House of Delegates, all suggestions and proposals for modification of the Constitution & Bylaws;
- 2) Prepare for the consideration of the House of Delegates, all changes in the Constitution & Bylaws; and
- 3) Maintain constant surveillance of both documents to keep them current, effective and consistent with the policies of the House of Delegates.

The Speaker of the House of Delegates shall be an ex-officio member of this committee.

COMMITTEE ON CONTINUING EDUCATION
(Council on Education and Manpower)

Herschel L. Browns, *Chairman*
4600 N. Ravenswood, Chicago 60640
Dean R. Bordeaux, *Vice-Chairman*
2421 W. Rohmann Ave., Peoria 61604
Kenneth W. Anderson
8501 Cottage Grove, Chicago 60619
James A. Felts
517 Bainbridge Rd., Marion 62959
Robert E. Fitzgerald
542 Duane, Glen Ellyn 60137
Leo R. Green
1114 Milton Road, Alton 62002
William F. Hubble
38 S. Shore Drive, Decatur 62521
Mays C. Maxwell
4202 Bond Street, East St. Louis 62207
John C. Rathe
1505-7th St., Moline 61265
Forrest H. Riordan, III
5670 E. State St., Rockford 61108
Robert J. Shafer
404 W. Washington, Petersburg 62675
Herbert Sohn
4640 N. Marine, Chicago 60640
Gordon H. Sprague
502 Shaw Ave., Paris 61944
SAMA REPRESENTATIVE:
Kong Meng Tan
1926 W. Harrison, Chicago 60612
CONSULTANTS:
George Shropshear
1525 E. 53rd St., Chicago 60615
Fred Z. White
723 N. 2nd St., Chillicothe 61523
STAFF: Perry L. Smithers

Responsibilities and Purposes

The committee is responsible for encouraging physicians of Illinois to keep abreast of medical advances by participating in various types of continuing education programs. It should be aware of the agencies offering continuing education courses, measure the value of such courses where possible and strive to coordinate them in order to prevent duplication and uncover significant gaps in types of courses available.

The committee should consider itself a monitoring arm of ISMS rather than an operational arm, except that where specific areas of continuing education are not available to Illinois physicians, it should take whatever steps are necessary to provide necessary programs.

The prime responsibility of the committee is to maintain the excellence of the profession by encouraging ISMS members to "keep up" by participating in acceptable continuing education programs.

The committee shall be responsible for operating a Scientific Speakers Bureau through which county medical societies can obtain scientific speakers for its programs.

SUB-COMMITTEE ON DRUGS AND THERAPEUTICS

Robert C. Muehrcke, *Chairman*
518 N. Austin Blvd., Oak Park 60302
Joseph D. Cece
120 Oakbrook Center, Oak Brook 60521
Charles R. Frazer, Jr.
1401 Gaty Ave., East St. Louis 62201
Richard L. Landau
950 E. 59th St., Chicago 60637
W. H. Walton
109 S. High St., Belleville 62220
CONSULTANTS:
Louis Gdalan, R.Ph.
Presbyterian-St. Luke's Hospital
1753 W. Congress St., Chicago 60612
Henry A. Holle
160 N. LaSalle St., Chicago 60610
Room 2000
A. E. Livingston
219 N. Main St., Bloomington 61701
STAFF: Mrs. Pat Uznanski

Responsibilities and Purposes:

The Committee will operate as a sub-committee of the Advisory Committee to the Illinois Department of Public Aid and will continue to work with the department in an effort to keep the Drug Manual current and effective. When suggestions and comments from the members are submitted to the committee, it will review them and present them to the Department of Public Aid when necessary. The committee will also consider other drug matters affecting the policy of the medical society.

ETHICAL RELATIONS COMMITTEE (Board of Trustees)

William M. Lees, *Chairman*
6518 North Nokomis, Lincolnwood 60646
James B. Hartney
410 Lake Street, Oak Park 60302
L. T. Fruin
5 Citizen's Square, Normal 61761
Fred Z. White
723 N. Second Street, Chillicothe 61523

Responsibilities and Purposes:

The responsibilities and purposes of this committee are outlined in CHAPTER XI. DISCIPLINE, Part 2 *Illinois State Medical Society Procedure*

Section 1. Illinois State Medical Society Ethical Relations Committee. The Board of Trustees shall appoint from its members an Ethical Relations Committee to review decisions of the component society involving the interpretation of the Principles of Medical Ethics, violations of the Constitution and By-laws of the Illinois State Medical Society or its component societies and charges of misconduct of members of the Society.

Section 2. Appeals from Component Society Verdicts. Appeals received by the Illinois State Medical Society Board of Trustees shall be referred to the Ethical Relations Committee of the Board for review. (Appeals must be ac-

companied by a comprehensive stenographic record of the proceedings taken before the component county society together with all exhibits submitted in evidence. If the component county society fails to provide the record on appeal, the Ethical Relations Committee of Illinois State Medical Society shall find the accused "not guilty"). The committee shall notify the accused and the secretary of the component society by certified mail at least thirty days prior to the date set for the hearing of the appeal. The chairman of the committee shall preside over the hearing in accordance with the rules established by the Board of Trustees.

Section 3. Verdict. The Ethical Relations Committee of the Board of Trustees shall hear any new and pertinent evidence any interested party desires to present, and at the conclusion of the trial, the decision of the component society shall be affirmed, overruled or sent back to the component society for reconsideration.

Section 4. Notification and right of appeal. The secretary of the Society shall notify the defendant and the secretary of the component society wherein the defendant holds membership, of the action of the Board. In the event of a decision against the accused he shall have the right to appeal the decision to the Judicial Council of the American Medical Association and the secretary of the State Society shall so notify the accused of this right.

EXECUTIVE COMMITTEE (Board of Trustees)

Willard C. Scrivner, *Chairman*
4601 State St., East St. Louis 62205
Joseph L. Bordenave
1665 South St., Geneva 60134
Mather Pfeifferberger
State and Wall Sts., Alton 62002
L. T. Fruin
5 Citizen's Square, Normal 61761
J. Ernest Breed
55 East Washington St., Chicago 60602

Jacob E. Reisch
1129 South 2nd St., Springfield 62704
Frank J. Jirka, Jr.
1507 Keystone Avenue, River Forest 60305
Edward W. Cannady
4601 State St., East St. Louis 62205
STAFF: Roger N. White
Frances C. Zimmer

Responsibilities and Purposes:

The Executive Committee shall consist of the president, the president-elect, the chairman of the Board, the chairman of the Finance Committee, the chairman of the Policy Committee, the secretary-treasurer, the trustee-at-large and the immediate past chairman of the Board provided he is still a Trustee.

It may be given authority to act by the Board of Trustees.

In matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Policy Committees and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

Bylaws, Chapter IX, Part 4, Section 2. Paragraph A.

EAR NOSE & THROAT HEALTH COMMITTEE (Council on Legislation and Public Affairs)

John J. Ballenger, *Chairman*, 723 Elm Street, Winnetka
George H. Conner, 1725 West Harrison, Chicago
Paul H. Holinger, 700 North Michigan, Chicago
Richard E. Marcus, 64 Old Orchard, Skokie
William A. Weiss, 118 West Laurel Street, Springfield
Guy O. Pfeiffer, 213 South 17th Street, Mattoon

CONSULTANTS:

Meyer Fox, 2040 West Wisconsin Avenue, Milwaukee
Earl Harford, Northwestern Medical School, 303 East Chicago Avenue, Chicago

Maurice Hoeltgen, 1836 West 87th Street, Chicago
STAFF: Larry N. Booth

Responsibilities and Purposes

The function of the Ear Nose and Throat Health Committee is to concern itself with state legislation regarding Laryngological and Otological matters, to secure and disseminate information and make recommendations regarding specific legislative proposals. The Ear Nose and Throat Committee shall also work in connection with the Chicago Laryngological and Otological Society.

EYE HEALTH COMMITTEE (Council on Legislation and Public Affairs)

Frank J. Kresca, *Chairman*, 208 West Green, Champaign 61820

David L. Brown, 122 S. Michigan, Chicago 60603
Wilbur W. Baumgartner, 118 N. Chestnut, Kewanee 61443
James R. Fitzgerald, 6429 North Avenue, Oak Park 60302
Max Hirschfelder, Box 529, Centralia 62801
Edward Kwedar, 615 S. 7th, Springfield 62703
Lawrence J. Lawson, 636 Church St., Evanston 60201
Charles L. Pannabecker, 331 Fulton Street, Peoria 61602
Manuel L. Stillerman, 111 N. Wabash, Chicago 60602
M. Byron Weisbaum, 520 E. Allen Street, Springfield 62703

Maurice M. Hoeltgen, 1836 West 87th Street, Chicago 60620

CONSULTANTS:

William A. McNichols, Jr., 101 West 1st Street, Dixon 61021

STAFF: H. Michael Wild and Larry N. Booth

Responsibilities and Purposes

The function of the Eye Health Committee is to concern itself with state legislation regarding ophthalmic matters, to secure and disseminate information and make recommendations regarding specific legislative proposals. The Eye Committee also meets with the Illinois State Joint Council of Ophthalmology to study problems and formulate policy on the medical and social-economic aspects of ophthalmology.

FINANCE COMMITTEE (Board of Trustees)

Mather Pfeiffenberger, *Chairman*
State & Wall Streets, Alton 62002

Jacob E. Reisch
1129 South 2nd Street, Springfield 62704

William M. Lees
6518 North Nokomis, Lincolnwood 60466

Fred Z. White
723 North Second Street, Chillicothe 61523

STAFF: Roger N. White
Sandie Koelbel

Responsibilities and Purposes:

The Finance Committee shall consist of the secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop for approval of the Board through the Executive Committee, a budget for the fiscal year. It shall supervise the financial transactions of the Society. It shall make recommendations to the Board for the control and investment of the funds of the Illinois State Medical Society.

COMMITTEE ON HEALTH CARE FINANCING
(Board of Trustees)

Joseph R. O'Donnell, *Chairman*
444 Park, Glen Ellyn 60137
James B. Hartney
410 Lake St., Oak Park 60302
Frank J. Jirka, Jr.
1507 Keystone Ave., River Forest 60302
Frederick E. Weiss
15643 Lincoln, Harvey 60426
Eugene P. Johnson
22 W. Main St. Casey 62420
Joseph L. Bordenave
1665 South St., Geneva 60134
CONSULTANT:
Jacob E. Reisch
1129 S. Second St., Springfield 62704
STAFF: Joseph Lotharius

Responsibilities and Purposes:

The Committee on Health Care Financing shall consider new concepts of health care delivery and submit recommendations to the Board on the feasibility of implementing such concepts at the county, district and or state level. The committee shall also define the usual, customary, and reasonable fee concept and assure its adherence throughout the state. In performing this function, the committee shall meet with representatives of health insurance carriers, government intermediaries and other third parties. It shall also review the adequacy and appropriateness of physician reimbursement in accordance with ISMS policies.

AD HOC COMMITTEE ON HOSPITAL RELATIONS
(Council on Social and Medical Services)

Julian Buser, *Chairman*, 4601 State St., East St. Louis 62205
Standby ad hoc committee; committee members to be appointed when needed.

COMMITTEE ON IMPARTIAL MEDICAL TESTIMONY
(Medical-Legal Council)

Vincent Sarley, *Chairman*, 811 West Wellington, Chicago 60657
Dennis Dorsey, Box 487, Winfield 60190
Jerome J. McCullough, 100 North High Street, Belleville 62220
Maurice D. Murfin, 250 North Water St., Decatur 62523
Ronald Shlensky, 251 East Chicago, Chicago
CONSULTANTS:
Samuel Levinson, 3730 Lake Shore Drive, Chicago 60613
Clinton Compere, 737 North Michigan, Chicago 60611
James B. Hartney, 410 Lake Street, Oak Park 60302
STAFF: H. Michael Wild

Responsibilities and Purposes

The Committee shall cooperate with the judiciary in both federal and state courts within the state of Illinois. It shall, when requested by the court, implement the Impartial Medical Testimony panel. The stated objective of the panel is to provide consultations, judgment and opinions in personal injury situations in which there is unusual controversy or wide divergence of medical opinion.

COMMITTEE ON INSURANCE
(Council on Public Relations & Membership Services)

Clifton L. Reeder, *Chairman*
734 N. Merrill Ave., Park Ridge 60068
Philip D. Boren
507 W. Main, Carmi 62821
A. Everett Joslyn
557 Keystone Ave., River Forest 60305
James B. Flanagan
10448 S. Crawford Ave., Oak Lawn 60453
Lawrence Knox
600 E. Main, Olney 62450
CONSULTANTS:
A. Edward Livingston
219 N. Main, Bloomington 61701
Jacob E. Reisch
1129 S. 2nd St., Springfield 62704
Fred Z. White
723 N. Second St., Chillicothe 61523
STAFF: Marian Thiele

Responsibilities and Purposes:

The Committee on Insurance will review society-sponsored insurance programs, which are currently the Tax Qualified Investment Program (Keogh), Retirement Investment Program, Group Disability Program, Group Major Medical Program and Professional Liability Insurance Program. The committee will study these plans, make suggestions for changes, additions and cancellation of policies, and investigate other insurance programs that may benefit society members.

COMMITTEE ON LABORATORY SERVICES (Medical-Legal Council)

Joseph Sherrick, *Chairman*, 1128 Jeffrey Court, West Northbrook

Ronald Jessen, 350 North Wall Street, Kankakee 60901

John J. Mueller, 24 Logan Fairmont Addition, Alton 62002

Peter Soto, 211 S. Third Street, Belleville 62221

Hans Willuhn, 1335 Charles Street, Rockford 61108

Jack Williams, 130 E. Randolph, Chicago 60601

CONSULTANT:

James B. Hartney, 410 Lake Street, Oak Park 60302

STAFF: H. Michael Wild

Responsibilities and Purposes

The committee shall effect methods of elevating and maintaining the standards of medical laboratories in Illinois, encourage the use of medical diagnostic laboratories supervised by duly qualified physicians, and encourage each county and district to establish evaluation committees.

COMMITTEE ON LICENSURE (Medical-Legal Council)

Ross Hutchison, *Chairman*, 126 East 9th Street, Gibson City 60936

Wilson West, 7300 State, East St. Louis 62203

Clay Jones, 3233 South Park Avenue, Chicago 60616

Henry Boldt, 3526 N. California, Peoria, Illinois

Raymond B. Murphy, R. 3, Box 19, Robinson 62454

Morgan Meyer, 815 South Main, Lombard 60148

William T. Davin, 9701 West Grand Avenue, Franklin Park

Earl Klaren, 158 E. Cook Street, Libertyville 60048

CONSULTANTS:

Charles K. Wells, 117 N. 10th St., Mt. Vernon 62864

Joseph L. Bordenave, 1665 South St., Geneva 60134

Frank J. Jirka, Jr., 1507 Keystone, River Forest 60305

STAFF: H. Michael Wild

Responsibilities and Purposes

The committee shall concern itself with the illegal practice of medicine and other healing arts groups associated with unfounded claims for cure of disease. It shall cooperate with the legal authorities of the state, such as the office of the Attorney General and the Department of Registration and Education and concern itself with the general problems of licensure. It shall cooperate with the AMA's Department of Investigation and other agencies interested in this field.

COMMITTEE ON MATERNAL WELFARE (Council on Environmental and Community Health)

Robert R. Hartman, *Chairman*

1515A Walnut St., Jacksonville 62650

Frederick H. Falls, *Chairman Emeritus &*

Special Consultant

Box 47, River Forest 60305

DISTRICT

MEMBERS AND ALTERNATES
(alternates in italics)

1. William R. Larsen

13707 W. Jackson, Woodstock 60098

Gordon T. Burns

2300 N. Rockton, Rockford 61101

2. William J. Farley

710 Peoria St., Peru 61354

Donald M. Gallagher

Box 538, Granville 61326

3. Melvin Goodman

13826 Lincoln Ave., Dolton 60419

Charles F. Kramer

12647 Justine St., Calumet Park 60643

4. V. B. Adams

301 E. Jefferson, Macomb 61455

Ralph Gibson

416 St. Marks Ct., #410, Peoria 61603

5. William W. Curtis

100 W. Miller St., Springfield 62702

Robert Maletich

1025 S. 7th St., Springfield 62703

6. Robert R. Hartman

1515A Walnut St., Jacksonville 62650

Richard Yoder

601 E. 3rd, Alton 62002

7. Paul A. Raber

149 W. King St., Decatur 62521

Hubert Magill

1170 E. Riverside, Decatur 62521

8. John C. Mason Jr.

715 N. Logan Ave., Danville 61832

John R. Powell

602 W. University Ave., Urbana 61801

9. Harry J. Lewis

104 S. Maple, Benton 62812

Donald R. Risley

319 Market St., Mt. Carmel 62863

10. James B. Stotlar

15 N. Walnut, Pinckneyville 62274

William R. Malony

Box 1030, Carbondale 62901

11. John J. McLaughlin

2100 Glenwood, Joliet 60435

Charles P. Westfall

172 Schiller St., Elmhurst 60126

CONSULTANTS:

John Louis
10721 S. Hoyne, Chicago 60643
Willard C. Scrivner
4601 State St., East St. Louis 62205
Augusta Webster
707 N. Fairbanks Ct., Chicago 60611
Franklin D. Yoder
535 W. Jefferson St., Springfield 62707
STAFF: Perry L. Smithers

Responsibilities and Purposes

The committee shall cooperate with the State Department of Public Health in reducing the maternal mortality rate in Illinois. As a means of achieving this goal, it shall review all maternal deaths reported and send its evaluation of the management of the case to the attending physician. Appropriate measures should be taken to share the results of this research with those practitioners in a position to apply it for the benefit of their patients.

COMMITTEE ON MEDICINE & RELIGION (Council on Public Relations and Membership Services)

Anna A. Marcus, *Chairman*
5852 W. North, Chicago 60639
William B. Rich
1400 S. 1st Ave., Hines 60141
Clement P. Cunningham
2526 18th Ave., Rock Island 61201
Charles W. Pfister
5511 N. Harlem Ave., Chicago 60656
William H. Whiting
Box 410, 525 N. Main, Anna 62906
David J. Kweder
4 S. Genesee St., Waukegan 60085
CONSULTANTS:
Rev. Herman Cook
Chaplains Office, University of Chicago Hospitals
950 E. 59th St., Chicago 60637
Rabbi Mordecai Simon
Chicago Board of Rabbis, Suite 500
72 E. 11th Street, Chicago 60605

Father John Marren
Holy Trinity Church, 916 S. Wolcott Chicago 60612
Warren Young
10816 Parnell Ave., Chicago 60628
AUXILIARY REPRESENTATIVE:
Mrs. Sherman C. Arnold
2416 Brookwood Ave., Flossmoor 60422
SAMA REPRESENTATIVE:
Nancy Stoit
902 S. Dunlop, Forest Park 60130
STAFF: Marian Thiele

Responsibilities and Purposes:

The primary purpose of the Committee on Medicine and Religion is to assist in establishing similar committees on the county level. It is also responsible for creating closer ties between physicians and the clergy, leading to total patient care.

COMMITTEE ON NARCOTICS (Council on Mental Health and Addiction)

Joseph H. Skom, *Chairman*
707 N. Fairbanks Court, Chicago 60611
Richard B. Eisenstein
111 N. Wabash, Chicago 60602
Jerome H. Jaffe
950 E. 59th St., Chicago 60637
Kermit T. Mehlinger
3312 W. Grenshaw, Chicago 60614
Harry W. Parks
Memorial Hospital, N. Park Drive, Belleville 62223
George Silvest
114 E. Everett, Dixon 61021
David Slight
25 E. Washington St., Chicago 60602
SAMA REPRESENTATIVE:
Robert Strauss
61 E. Goethe St., Chicago 60610

CONSULTANT:
Wm. A. McNichols, Jr.
101 W. 1st St., Dixon 61021
STAFF: Perry L. Smithers

Responsibilities and Purposes

The functions of the Committee are: (1) study, research and dissemination of educational information on narcotics and hazardous substances to members of the medical profession; (2) to recommend acceptable measures for the control of distribution, the use and disposal of narcotics and hazardous substances, exclusive of radiation products but including poison control, and (3) to cooperate with official and non-official agencies in all matters pertaining to this subject.

COMMITTEE ON NURSING
(Council on Social and Medical Services)

William A. Hutchison, *Chairman*
4753 N. Broadway, Chicago 60640
David M. Greeley
1130 Michigan Ave., Evanston 60202
Jaroslav F. Neskodny
6820 Windsor Ave., Berwyn 60402
H. J. Kolb
303 Sherman, St. Joseph 61873
Roger Sondag
535 W. Jefferson St., Springfield 62706
CONSULTANTS:
Mrs. Helen Grace
University of Illinois, P.O. Box 6998
Chicago 60680
Mrs. Joyce Taylor
363 E. Burlington, Riverside 60546

AUXILIARY REPRESENTATIVE:
Mrs. Thomas Glatter
2407 Spring Brook Ave., Rockford 61107
STAFF: Marian Thiele

Responsibilities and Purposes:

The primary purpose of the Committee on Nursing is to establish a close professional relationship between physicians and nurses and to assist in recruiting programs to help relieve the current nursing shortage. The committee will also work to improve educational programs for nurses, working relationships between physicians and nurses in hospitals, and the nurses' hospital duties, to utilize their full potential and skill.

COMMITTEE ON NUTRITION
(Council on Environmental and Community Health)

Eugene F. Diamond, *Chairman*
11055 S. St. Louis, Chicago 60655
Sheldon Berger
707 N. Fairbanks Ct., Chicago 60611
William R. Clarke
1211 S. Independence Blvd. Chicago 60623
Allen A. Filek
1806 Maple, Box 870, Evanston 60204
Elliot G. Goldin
5214 N. Western Avenue, Chicago 60625
Ben A. Kinsman
20 N. Washington, DuQuoin 62832
Alfred D. Klinger
5229 Woodlawn Ave., Chicago 60615
Philip Lynch
1314 N. Main, Decatur 62526
Rene St. Leger
3909 State St., East St. Louis 62205
John E. Walters
231 E. 75th St., Chicago 60619

CONSULTANTS:
Paul A. Dailey
620 N. Main St., Carrollton 62016
George Shropshear
1525 E. 53rd St., Chicago 60615
STAFF: Perry L. Smithers

Responsibilities and Purposes

The committee shall serve as a source of information on nutrition matters for the ISMS and evaluate available information and make recommendations to the Board of Trustees for the position the ISMS should take on issues in this area. It shall cooperate with institutions and voluntary health agencies in disseminating information on nutrition subjects to the profession and to the public. It shall be on the alert for misleading or fallacious programs and information which need correction for the protection of the public.

COMMITTEE TO STUDY OSTEOPATHIC PROBLEMS
(Board of Trustees)

Arthur F. Goodyear, *Chairman*
142 East Prairie Street, Decatur 62523
Eugene P. Johnson
22 West Main Street, Casey 62420
Frederick E. Weiss
15643 Lincoln, Harvey 60426
Fredric D. Lake
1041 Michigan Avenue, Evanston 60202
STAFF: Roger N. White

Responsibilities and Purposes:

The responsibilities of this committee are to assist in developing rapport, cooperation with and an understanding of the osteopathic profession. The committee shall study and report on the present situation in Illinois in view of recent action by the House of Delegates which permits qualified osteopaths to be members of the Medical Society.

POLICY COMMITTEE
(Board of Trustees)

Responsibilities and Purposes:

The Policy Committee shall consist of three members of the Board appointed by the chairman. It shall continually review past and current proceedings of the House of Delegates to determine the established policies of the Illinois State Medical Society. It shall make recommendations for future policy by Board resolution to the House of Delegates.

Joseph L. Bordenave
1665 South Street, Geneva 60134
James B. Hartney
410 Lake Street, Oak Park 60302
William A. McNichols Jr.
101 West 1st Street, Dixon 61021
STAFF: Frances C. Zimmer

COMMITTEE ON PUBLIC AFFAIRS
(Council on Legislation and Public Affairs)

John W. Ovitz Jr., *Chairman*, 204 West Elm, Sycamore 60118

Herbert Sohn, *Co-Chairman*, 4640 N. Marine Drive, Chicago 60640

William Ashley, 6545 West 33rd Street, Berwyn 60402

William W. Boswell, 2500 North Rockton, Rockford 61103

Herschel L. Browns, 4600 North Ravenswood Avenue, Chicago

James E. Coeur, 630 Locust Street Carthage 62321

Edwin L. Falloon, 9534 S. Central Park, Evergreen Park

Justin Fleischmann, 320 S. Ela Road, Palatine 60067

George J. Gertz, 2376 E. 71st Street, Chicago 60649

J. R. Shackelford, Medical Center Clinic of Paris, Paris 61944

William J. Hillstrom, 280 Virginia Avenue, Crystal Lake 60014

James Heersma, 117 N. 10th St., Mt. Vernon 62864

Rocco Lobraico, Jr., 4833 Peterson, Chicago 60646

Earl V. Klaren, 158 E. Cook St., Libertyville 60048

W. Robert Malony, Carbondale Clinic, Carbondale 62901

Charles Downing, 1067 W. Main, Decatur 62522

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Earle Walker, 203 North Vine, Harrisburg 62946

Stanley E. Ruzich, 9944 S. Damen, Chicago 60643

James H. Geist, 12 Old Orchard, Route 5, Kankakee

John L. Savage, 723 Elm St., Winnetka 60093

Julius P. Schweitzer, 120 Oakbrook Mall, Oak Brook 60521

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Eugene H. Siegel, 103 Haven Road, Elmhurst 60126

Lorin D. Whittaker, 840 Jefferson Building, Peoria 61602

CONSULTANTS:

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L. T. Fruin, 5 Citizen's Square, Normal 61761

Frederick E. Weiss, 15318 Center Avenue, Harvey 60426

AUXILIARY REPRESENTATIVES:

Mrs. H. J. Failor, 9 Litchfield Lane, Champaign 61120

Mrs. Harry Parks, 25 High Forest, Belleville 62221

SAMA REPRESENTATIVE:

Steven Lipnik, 416 West 5th Street, Momence, Ill. 60954, 815/472-2529

STAFF: Timothy D. Selleck

Responsibilities and Purposes

The Public Affairs Committee is concerned with the political process as it pertains to medicine and public health. Within this broad context, appropriate education of the public is basic to continued health improvement in a free society. The electorate must make its wishes known to public officials.

The Public Affairs Committee shall strive to generate interest in the overall field of politics to enable the physician to participate effectively. Programs of public affairs orientation, political education and campaign characteristics will be undertaken to increase the effectiveness of the physician in public affairs.

COMMITTEE ON PUBLIC SAFETY
(Council on Environmental and Community Health)

James P. Campbell, *Chairman*

322 N. Blanchard St., Wheaton 60187

William Hark

30 N. Michigan, Chicago 60602

Edward W. Holmblad

1350 N. Lake Shore Dr., Chicago 60610

Max Klinghoffer

127 E. Vallette St., Elmhurst 60126

Julius Kowalski

436 Park Ave., E., Princeton 61356

Norman J. Rose

535 W. Jefferson St., Springfield 62607

William J. Schnute

737 N. Michigan, Chicago 60611

Clifford P. Sullivan

2800 W. 87th St., Chicago 60652

SAMA REPRESENTATIVE:

Robert Luther

833 W. Buena, Chicago 60613

AUXILIARY REPRESENTATIVE:

Mrs. Arthur Smith

206 Country Club Lane, Belleville 62223

STAFF: Petty L. Smithers

Responsibilities and Purposes

The Committee shall study the medical aspects of accident prevention; alert the public to seasonal health hazards; and co-operate with the Illinois Department of Public Health, the National Safety Council and similar organizations.

PUBLICATIONS COMMITTEE
(Board of Trustees—Board Committee)

Jacob E. Reisch, *Chairman*

1129 South Second Street Springfield 62704

A. Edward Livingston

219 North Main Street, Bloomington 61701

Warren W. Young

10816 Parnell Avenue, Chicago 60628

STAFF: Richard A. Ott

Responsibilities and Purposes:

The Publications Committee shall be composed of members of the Board of Trustees, and shall be responsible for the production of the *Illinois Medical Journal* and other Society publications.

It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the Journal. It shall supervise the editor in the selection and preparation of all copy, and it shall establish standards for the editorial content.

It shall establish advertising policies, rates, and standards, and shall review all new accounts prior to acceptance, and shall approve reprint and circulation policies.

It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish the format, cover, type faces and general layout of the Journal.

EDITORIAL BOARD
(Sub-Committee of Publications Committee)

Frederick Steigman, *Chairman*
1825 West Harrison Street, Chicago 60612
Edward DuVivier
1900 Brown Street, Alton 62002
Arthur DeBoer
720 North Michigan Ave., Chicago 60611
Donald L. Unger
2474 Dempster, Des Plaines 60016
Joseph H. Kiefer
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108 West 4th Street, Sterling 61081
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Newton DuPuy
1842 Grove, Quincy 62301
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1000 Lake Shore Plaza, Chicago 60610
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2160 South First Ave., Maywood 60153
Harvey Kravitz
5830 Dempster, Morton Grove 60053
RESIDENT: Neil Allen
7135 Carol St., Niles 60648
STAFF: Richard A. Ott

Responsibilities and Purposes:

The responsibilities of this committee lie in the area of the editorial content of the *Illinois Medical Journal*. It will function as a sub-committee of the Publications Committee. It shall make recommendations to the editor concerning the scientific content, regular features and subjects of special interest to the members. It shall serve as a review board for manuscripts which the editor believes require special medical evaluation. It shall assist the editor in any way possible to obtain and present medical manuscripts of the highest quality and maximum interest to the physicians of Illinois.

AD HOC COMMITTEE ON RADIATION
(Council on Environmental and Community Health)

Howard A. Burkhead, *Chairman*
2650 Ridge Ave., Evanston 60201
(Standby *ad hoc* committee; committee members to be appointed when needed.)

COMMITTEE ON REHABILITATION SERVICES
(Council on Social and Medical Services)

Joel Rosen, *Chairman*
3950 Lake Shore Drive, Chicago 60613
John E. Finch
135 S. Kenilworth, Elmhurst 60126
Frank B. Kelly, Jr.
122 S. Michigan Ave., Chicago 60603
Joseph L. Koczur
10039 Turner, Evergreen Pk., Chicago 60642
John G. Meyer
413 W. Monroe, Springfield 62704
James C. Reid
712 S. College, Greenfield 62044
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12800-93rd Ave., Box 35, Palos Park 60464

CONSULTANTS:
Charles K. Wells
117 N. 10th, Mt. Vernon 62864
Frank J. Jirka, Jr.
1507 Keystone, River Forest 60305
STAFF: Robert Westerbeck

Responsibilities and Purposes:

The Committee on Rehabilitation Services shall assist public and private agencies in the establishment of policies regarding rehabilitation facilities and services, including training, and quality and type of services available. The committee also works closely with the Governor's Committee on Employment of the Handicapped.

COMMITTEE ON SCIENTIFIC ASSEMBLY
(Council on Education and Manpower)

Robert T. Fox, *Chairman*
2136 Robin Crest Lane, Glenview 60025
J. Robert Thompson, *Director of Exhibits*
5601 N. Pulaski, Chicago 60646
Roger Hoekstra
1530 North Main Street, Wheaton 60187
Laurel E. Keith
1725 West Harrison, Chicago 60612

Elizabeth A. McGrew
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2474 Dempster St., Des Plaines 60016
SAMA REPRESENTATIVE:
Gerald Stanton
11003 S. Longwood Dr., Chicago 60643

AUXILIARY REPRESENTATIVE:

Mrs. Mitchell Spellberg
1212 N. Lake Shore, Chicago 60611
STAFF: Perry L. Smithers

Responsibilities and Purposes

The Committee on Scientific Assembly shall coordinate the program for the Annual Convention in accordance with Chapter II of the Constitution and Bylaws-*Annual Convention*; it shall appoint, with the approval of the

Board of Trustees, a secret committee to make awards to the scientific exhibitors; may incorporate in the annual scientific meeting those meetings of medical specialty groups which wish to affiliate with the ISMS annual convention, and shall arrange for the annual banquet and other functions held during the annual convention.

The scientific program shall be conceived by the Committee on Scientific Assembly and developed and implemented through the joint efforts of the Committee on Scientific Assembly and representatives of specialty groups.

**ADVISORY COMMITTEE TO THE STUDENT AMERICAN MEDICAL ASSOCIATION
(Council on Education and Manpower)**

T. Howard Clarke, *Chairman*
999 Lake Shore Dr., Chicago 60611
Allison Burdick, Jr.
5906 W. North Ave., Chicago 60639
N. Kenneth Furlong
221 N. East Glen Oak Ave., Peoria
Nathan Iglitzen
836 W. Wellington, Chicago 60657
Courtney P. Jones
11045 S. Vincennes, Chicago 60643
Louis R. Limarzi
910 N. East Ave., Oak Park 60302
Clarence Walton
602 W. University Ave., Urbana 61801
SAMA REPRESENTATIVES:
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Eugene Saltzberg
722 W. Grace St., Chicago 60613

Ronald Ban
822 S. Miller, Chicago 60607
Donald Batts
2342 S. 59th Ct., Cicero 60650
AUXILIARY REPRESENTATIVE:
Mrs. G. F. Tufo
750 W. Hutchinson, Chicago 60613
STAFF: Perry L. Smithers

Responsibilities and Purposes

The committee is charged with the responsibility of maintaining liaison with officers of Student AMA Chapters in Illinois; establishing programs to acquaint medical students with the principles of organized medicine; and developing programs designed to advance the purposes of both organizations.

**COMMITTEE ON STUDENT LOAN FUND
(Council on Education and Manpower)**

Donald Stehr, *Chairman*
102 E. Market, Havana 62644
Jack Gibbs
24-26 Main Street, Canton 61520
Charles Salesman
1201 N. Allen St., Robinson 62454
CONSULTANTS:
L. T. Fruin
5 Citizen's Square, Normal 61761
Jacob E. Reisch
1129 S. 2nd St., Springfield 62704
STAFF: Perry L. Smithers

Responsibilities and Purposes

The committee shall be responsible to the Board of Trustees in matters related to administration of the Student Loan Program operated jointly with the Illinois Agricultural Association.

**ADVISORY COMMITTEE TO THE
DIVISION OF VOCATIONAL REHABILITATION
(Council on Economics and Peer Review)**

Eli Borkon, *Chairman*
Carbondale Clinic, Carbondale 62901
Joseph Compton
4601 State St., East St. Louis 62204
Thomas R. Glatzer
5670 E. State St., Rockford 61108
Harry Grant
701 N. Walnut, Springfield 62702
Brian H. Huncke
454 Pennsylvania Ave., Glen Ellyn 60137

Thaddeus S. Pierce
3340 S. Oak Park, Berwyn 60403
Aaron M. Rosenthal
1401 California, Chicago 60608
Harold A. Sofield
715 Lake, Oak Park 60301
A. Walter Wise
502 Safety Building, Rock Island 61201
Gerald M. Berkowitz
1031 Cobblestone Ct., Northbrook 60062

CONSULTANTS:

Charles K. Wells
117 N. 10th St., Mt. Vernon 62864
Frank J. Jirka, Jr.
1507 Keystone Ave., River Forest 60305
STAFF: Joseph Lotharius

Responsibilities and Purposes:

The Advisory Committee to the Division of Vocational

Rehabilitation will meet regularly with the DVR staff on matters regarding the operation of the DVR medical program. It will submit advisory decisions to DVR on medical policy in the administration of the quality, quantity and cost of the various DVR programs. The committee should also foster a good relationship with DVR and provide a continuing program of physician education to familiarize ISMS members with the DVR program.

**ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY
(Board of Trustees)**

L. T. Fruin, *Chairman*
5 Citizen's Square, Normal 61761
J. Ernest Breed
55 East Washington, Chicago 60602
Willard C. Scrivner
4601 State Street, East St. Louis 62205
STAFF: Roger N. White

Responsibilities and Purposes:

The committee shall consist of the president-elect as chairman, the president, the chairman of the Board. The committee shall provide advice and assistance to the president of the Woman's Auxiliary in her program for the year, and shall assist her in interpreting the activities of the state medical society to the auxiliary members.

Task Forces

To consider specific activities and give full concentration of council and staff effort to a single problem, task forces will be formed. These will function until the objective has been met and will then be dissolved. Said groups will cross functions with many councils and committees and will consist of members of other councils and committees. They will report directly to the Board of Trustees.

TASK FORCE ON COMPREHENSIVE HEALTH PLANNING

V. P. Siegel, *Chairman*, 4601 State Street, East St. Louis 62205
Thomas P. deGraffenried, 1208 Sunnymead, DeKalb 60115
John Howard Kendall, 502 W. Palladium Drive, Joliet 60431
Philip Lynch, 1314 North Main, Decatur
E. A. Piszczek, 6410 North Leona Avenue, Chicago 60646
Fred Z. White, 723 North 2nd, Chillicothe
CONSULTANTS:
Clarke Mangum, 535 North Dearborn, Chicago (AMA)
Clifton Reeder, 734 North Merrill, Park Ridge 60068
Frank J. Jirka, Jr., 1507 Keystone, River Forest 60305
Thomas Harwood, 4902 Tollview Dr., Rolling Meadows 60008
STAFF: H. Michael Wild

Responsibilities and Purposes

1. To keep abreast of all developments in the State of Illinois with respect to Comprehensive Health Planning.
2. To make recommendations as to the manner in which ISMS can initiate and maintain a position of leadership in Comprehensive Health Planning.
3. To establish and maintain a close liaison with the official state agency designated to administer the law.

**TASK FORCE ON PHYSICIAN SHORTAGE
AND
SERVICES TO MEDICALLY DEPRIVED AREAS**

William M. Lees, *Chairman*
6518 N. Noklmis, Lincolnwood 60646
Philip G. Thomsen
13826 Lincoln Ave., Dolton 60419
Jack Gibbs
24-26 Main Street, Canton 61520
Morgan Meyer
815 S. Main, Lombard 60148
Eugene Johnson
22 W. Main, Casey 62420
Robert Freark
803 Lake, Wilmette 60091
Thomas A. Reardon
1926 W. Harrison Chicago
Alfred J. Faber
2110 Swainwood Dr., Glenview 60025
Matthew Eisele
(Kil Mar Medical Bldg.)
8601 W. Main (Suite 209)
Belleville 62223

Donald Stehr
102 E. Market Havana 62644
Andrew Brislen
6060 S. Drexel, Chicago 60637
George Shropshear
1525 E. 53rd St., Chicago 60615
CONSULTANT:
James B. Hartney
410 Lake St. Oak Park 60302
STAFF: Jim Slawny

Responsibilities and Purposes:

The primary responsibilities of the task force are to initiate and implement programs to alleviate the physician shortage in Illinois—particularly in rural areas—and to assist in the development of projects to improve the health care of people in medically deprived areas, such as urban ghettos. It is also charged with the responsibility of developing a loan program for "inner city" medical students.

OTHER APPOINTMENTS

The Board of Directors of the Educational and Scientific Foundation, and representatives to other organizations report directly to the Board of Trustees periodically as necessary.

EDUCATIONAL AND SCIENTIFIC FOUNDATION

Edward W. Cannady, *Chairman*

4601 State St., E. St. Louis 62205

Willard C. Scrivner

4601 State St., E. St. Louis 62205

J. Ernest Breed

55 E. Washington St., Chicago 60602

L. T. Fruin

5 Citizen's Square, Normal 61761

Jacob E. Reisch

1129 S. 2nd St., Springfield 62704

STAFF: Perry Smithers

Responsibilities and Purposes

The foundation was founded to provide an ad-

ministrative agency to foster the advancement of medical science through (1) the initiation of scientific and medical research activities, (2) the collection, evaluation and dissemination of the results of research activities to the public and (3) the implementation and management of projects related to medicine for individuals or organizations seeking to inform or educate others, or to improve their own knowledge. The charter of the foundation calls for a board of directors consisting of the following officers of the Illinois State Medical Society: Immediate Past President (as chairman), Chairman of the Board of Trustees, President, and Secretary-Treasurer.

REPRESENTATIVES

ILLINOIS ASSOCIATION OF THE PROFESSIONS (IAP)

Frank J. Jirka, Jr., 1507 Keystone Ave., River Forest 60305

William M. Lees, 6518 North Nokomis, Lincolnwood 60646

SWANBERG FOUNDATION, QUINCY

Arnell M. Vaughn, 9012 S. Leavitt, Chicago 60620

HEALTH CAREERS COUNCIL OF ILLINOIS (HCCI)

Eugene P. Johnson, 22 West Main St., Casey 62420 (HCCI Board)

Allison Burdick, Jr., 5906 West North Avenue, Chicago 60639 (HCCI Board)

Casper Epstein, 25 East Washington, Chicago 60602 (Del. HCCI Senate)

Carl E. Clark, 225 Edward, Sycamore 60178 (Del. HCCI Senate)

MIDWEST REGIONAL LIBRARY ASSOCIATION

William E. Adams, 55 E. Erie St., Chicago 60611

LIAISON TO ILLINOIS MEDICAL ASSISTANTS ASSOCIATION

Carl E. Clark, 225 Edward St., Sycamore 60178

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ISMS SERVICES

Pursuit of Obligations

PURPOSES OF THE ILLINOIS STATE MEDICAL SOCIETY ARE:

- to promote the science and art of medicine
- to protect the public health
- to evaluate standards of medical education
- to unite the medical profession behind these purposes
- to unite with similar organizations in other states and territories of the United States to form the American Medical Association.

The Society shall inform the public and the profession concerning the advancements in medical science and the advantages of proper medical care.

To fulfill these purposes, the Society maintains a headquarters office at 360 N. Michigan Ave., Chicago, and an office in Springfield at 520 S. Sixth St. Services of the Society, under the gen-

eral supervision of Roger N. White, Executive Administrator, are conducted by the following divisions:

Administration; Public Relations and Economics; Legislation and Public Affairs; Publications; and Educational and Scientific Services.

Many and varied are the activities of the Society in pursuit of its obligations. Some of these activities are major programs of statewide (and sometimes national) interest for all citizens; others are of special interest to doctors; still others are sponsored for specific groups or individuals.

Following are descriptions of the Society's divisions and the programs, services and publications available directly to Society members or sponsored for their benefit.

DIVISION OF ADMINISTRATION

The Executive Administrator has the responsibility and the authority to provide for the smooth and efficient functioning of the Illinois State Medical Society.

The implementation of established policy, fiscal and budgetary matters, the employment of qualified personnel and the development and maintenance of personnel policies are all part of the Administrator's activities.

He maintains liaison with the Board of Trustees and assists the chairman in carrying out his duties. Close cooperation with the speaker of the House of Delegates and the officers of the Society provides a smooth and efficient atmosphere in which the Society may function. Cooperation is maintained with the Committee on Constitution and Bylaws to present to the House all suggested changes for official action. The Administrator channels all legal inquiries and works with the

General Legal Counsel to provide guidance to the officers, trustees, committee chairmen and county medical society officers.

To provide the membership of the Society with the best professional staff services available, headquarters has been set up by divisions. The Division of Administration provides the business services of the Society including the safekeeping and proper accounting for all money and securities under the guidance of the Board of Trustees, Finance Committee and the Secretary-Treasurer. A Field Services Representative is maintained within the Division to assist the Trustees in providing liaison between the Headquarters office and the county medical societies.

The Division also maintains the membership records and provides a computerized central dues billing and collection service for county medical societies.

DIVISION OF EDUCATIONAL AND SCIENTIFIC SERVICES

Committee Responsibilities

This division provides staff services for the Council on Education and Manpower, the Council on Environmental and Community Health, the Council on Mental Health and Addiction, and the eleven committees assigned to these councils.

Annual Convention

Similarly, the staff serves as an arm of the Committee on Scientific Assembly to arrange and

produce the annual convention of ISMS. Held in May each year, the convention offers scientific meetings and exhibits as well as sessions of the House of Delegates.

An additional function of the division is to administer the affairs of the Educational and Scientific Foundation, a non-profit organization established to conduct educational and scientific projects related to medicine. Physicians are invited to become Fellows of the Foundation for a charter membership of \$100.

DIVISION OF LEGISLATION AND PUBLIC AFFAIRS

As professional medicine strives to maintain the vigorous condition of the public health, the profession is vitally and intimately concerned with legislative actions of the Illinois General Assembly and the U. S. Congress which affect physicians, other members of the healing arts, and the lay public. To insure that the best health interests of the public and professional interests of the physician are served, the Division monitors all state and national legislation which affect the health of the individual and his community.

The monitoring process is designed to present the thoughtful views of professional medicine in Illinois on specific medically related pieces of legislation.

The ISMS Council on Legislation and Public Affairs acts as the clearing house for legislative proposals recommended by specialized ISMS committees; generated by allied groups; produced by special interests and introduced by representatives and senators. Such legislation is thoroughly analyzed by physician-members of the specialized ISMS committee covering the subject matter of the introduced legislation.

Support or Oppose Legislation

Upon appropriate consideration and recommendation, legislation of medical significance in the Illinois Legislature is either supported or opposed to protect and promote the interests of the public and the profession. Pertinent subject matter testimony is presented before the House and Senate committees as the bill proceeds through the legislative process.

On-the-scene surveillance of monitored legis-

lation is maintained by ISMS legislative representatives.

Through these essential actions, ISMS plays a meaningful role in shaping legislation for the betterment of the people of Illinois.

Action similar to the above is taken with respect to bills in Congress when they have special significance to Illinois physicians. This activity is conducted in concert with the American Medical Association.

Integrated with and designed to augment the legislative activity is the Public Affairs Program. This program, executed by the Division of Legislation and Public Affairs, as directed by the ISMS Public Affairs Committee, strives to alert the physician to his role in public affairs and to involve him in effective participation in public affairs in his community, state, and nation.

Other Activities

Divisional activities also includes other services. One of these, involving medicine, law, and the judiciary, is the administration of the Impartial Medical Testimony program. Operating in conjunction with the Supreme Court of Illinois and the Federal District Court, the services of impartial medical examiners are provided in personal injury cases.

Other facets of medical-legal interaction are explored through the Medical-Legal Council and problems resolved through liaison with committees of the judicial and the bar associations.

In addition to the foregoing, the division staffs the Committees on Laboratory Services, Licensure, Eye Health, and Ear, Nose and Throat Health.

DIVISION OF PUBLICATIONS

The Division of Publications is charged with the total production of all printed materials and publications as well as the distribution of these items.

Principal among the publications is the official organ of the society, the *Illinois Medical Journal*. The *Journal* is mailed monthly to all members who are urged to read it to keep abreast of the scientific, economic, political, legal and social developments within the state. The editor welcomes suggestions for articles which may be of special interest to the membership. All members should consider the *IMJ* a means of communicating with fellow Illinois practitioners.

Other publications are *Pulse*, a monthly newsletter, and such other special publications, brochures, pamphlets, flyers and letters as are required by the several ISMS divisions to carry forth their mission.

Within the division responsibility is maintained for all printing and duplicating services for the society; a small in-plant print shop is maintained along with modern reproduction and collating equipment.

In addition all mail room services are provided by this division. An addressograph and graphotype are utilized as well as a small wing mailer, folder and stuffing machine, and a plate burning cabinet. Mailing is accomplished through use of computer-supplied labels and the addressograph.

Within the *Illinois Medical Journal* and for *Pulse* commercial advertising is carried. The maintenance of the records of advertisers, insertion orders, contracts, and direct communication and liaison with advertising agencies and pharmaceutical houses fall within the purview of the division. These are accomplished through an advertising manager. Through this means and the ISMS representatives, the opportunity of presenting a product to members of ISMS through advertising in ISMS publications is offered.

Staff services for the Publications Committee and the Editorial Board are furnished through the division. Needs of groups affiliated with or ancillary to ISMS insofar as reproduction facilities are concerned are also handled through the division office.

DIVISION OF PUBLIC RELATIONS AND ECONOMICS

The Public Relations and Economics Division serves both as a news outlet to the press, and as a source of information on socio-economic and insurance matters to the membership.

With increasing frequency, the division is contacted by news writers seeking information on socio-economic, as well as scientific subjects. Its counseling services on public relations and publicity are available to any county medical society.

The division also prepares speeches, publishes pamphlets and other materials on subjects such as public aid in Illinois, medical care financing through Social Security, and physician retirement programs.

News Releases

A mailing list of all Illinois newspapers, radio and television stations is maintained by the division. The list is so arranged that news releases may be addressed to individual counties, and county society secretaries may avail themselves of this service.

News releases for county societies are automatically prepared by the division staff and distributed to all news outlets in the particular county whenever a county society makes use of

the ISMS post-graduate education program. Other than this, the state society's staff does not prepare news releases of county society activities unless this service is specifically requested.

Health Columns for Newspapers

Currently, ISMS presents daily public service health columns entitled "Dr. SIMS Says." These columns, offered to the 700 newspapers in Illinois, carry the logotype of Dr. "SIMS" which readily identifies the column with the Illinois State Medical Society.

Another public service column, being carried by some 375 high school newspapers throughout Illinois, is entitled "Dr. SIMS Talks to Teens." It is distributed on a monthly basis.

Public Aid Liaison

Familiarity with the medical care programs of the Illinois Department of Public Aid and liaison with the staff of the department are other responsibilities of the Division of Public Relations and Economics. Liaison is also maintained with public and private agencies interested in the fields of aging, insurance, hospitals, and rehabilitation.

The division provides staff services to the Councils on Economics and Peer Review, Social and Medical Services, and Public Relations and Membership Services, as well as the Task Force on Physician Shortage and Medically Deprived Areas.

THE EDUCATIONAL & SCIENTIFIC FOUNDATION

The Educational & Scientific Foundation was founded to provide an administrative agency to foster the advancement of clinical science through:

- 1) The initiation of scientific and medical research activities.
- 2) The collection, evaluation and dissemination of the results of research activities to the public.
- 3) The implementation and management of projects related to medicine for individuals or organizations seeking to inform or educate others, or to improve their own knowledge.

The Foundation is a distinct corporate entity which has an interlocking Board with the Illinois State Medical Society. It is staffed through ISMS headquarters.

FILMS

Stroke—Early Restorative Measures in Your Hospital

A film entitled "Stroke—Early Restorative Measures in Your Hospital," produced by the ISMS Committee on Aging, is available from the Society.

Directed toward physicians in all general hospitals, regardless of size, the film illustrates simple and effective methods and devices used in the rehabilitation of stroke patients. It emphasizes the procedures to be instituted immediately upon the patient's admission to the hospital.

Primary purpose of the film is to inform physicians and nurses of the need for immediate action in stroke cases and to interest them in acquiring additional details for treatment through available publications or study courses. The 20-minute sound, color film illustrates a program of constructive rehabilitation which may be conducted in any hospital, however small, by an interested nurse using a minimum of equipment.

The film may be obtained from the Society on a loan basis for viewing without charge or may be purchased for \$125.

Modern Management of Multiple Births

"Modern Management of Multiple Births" is a 16 mm. sound-color motion picture produced by the Educational and Scientific Foundation of the Illinois State Medical Society in cooperation with Lederle Laboratories Division of American Cyanamid Co.

Teaching "heart" of the film is step-by-step reconstruction of an elaborate protocol which serves as a standard of prenatal planning for

any physician faced with the management of multiple pregnancy.

For added teaching interest, the film reviews birth of identical quadruplets, showing how identity was established with major and minor blood typings, examination of placenta and fetal membranes and other procedures. There are also scenes of actual delivery of quadruplets.

Showings of the film are restricted to professional audiences. Organizations may borrow the film from Lederle Laboratories Film Library, Pearl River, N. Y., or from the Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601.

The Time of Your Life

A 13-part, 16 mm., black-and-white sound film is available to industry, church and civic groups, fraternal organizations, and medical societies, dealing with planning and participating in a happy, secure retirement. Successfully aired over TV, the video tapes have been converted to film for rental or purchase at \$60 for the former and \$975 for the latter.

This is a self-contained educational package which provides a once-in-a-lifetime opportunity for organizations to reach people who might otherwise be deprived of vital training in retirement planning. Since about one out of every three Americans will be retired within a generation it is essential that this message be put across to obviate unnecessary wasting of human resources and economic resources among the retired.

The film is available through the Division of Public Relations, ISMS.

SPECIAL PUBLICATIONS

Pulse

Pulse is a monthly newsletter published by the Illinois State Medical Society under a grant from Roche Laboratories, Division of Hoffmann La-Roche, Inc. It is distributed to all doctors in the state, to members of the Woman's Auxiliary and Illinois Medical Assistants Association, and is supplied in quantity to hospitals for interns, residents and other personnel.

Pulse carries non-scientific news, photographs and feature materials of interest to the medical profession in Illinois. A special section is devoted to the activities of the Woman's Auxiliary.

Comb-1 Insurance Form

Because of the variety of data required for health insurance claims, the Comb-1 Form was developed jointly by the American Medical Association and the Health Insurance Council to simplify and reduce the number of attending

physicians forms equally acceptable to the health insurance industry and the medical profession.

Information requested by many diverse forms from a large number of insurance companies was first classified and minimum needs for claim purposes were determined. Then appropriate and clearly worded questions were developed and arranged in a standard sequence, to facilitate completion. Out of this came two basic forms, one for group health insurance and one for individual health insurance, and four abbreviated forms. A further simplification involved devising an all-purpose form which is a combination of the group and individual forms—the Comb-1 Simplified Health Insurance Claim Form.

These forms are available to physicians from the Illinois State Medical Society and should be substituted for any non-standardized forms received. Each physician has been asked to voluntarily adopt the following procedure:

1) When a physician receives a form from an

insurance company bearing the HIC symbol it should be completed and returned to the company.

- 2) When a physician receives a form *not* identified by the HIC symbol, the standardized form should be filled out and clipped to the unacceptable form with both forms returned to the insurance company.
- 3) If the insurance company insists upon having its own form completed, the doctor should feel justified in making a reasonable charge for the added work involved in handling the non-standardized form.

The attempt to standardize these forms is an aid in cutting back on the ever-increasing load of paper work involved in medical practice. Forms are available without charge from the ISMS Division of Public Relations and Economics while the supply lasts.

Disaster Hospital Manual

The responsibility of providing immediate medical and hospital care in disasters of any magnitude falls directly on physicians, nurses and hospitals. To aid Illinois communities in developing

disaster plans, the ISMS Committee on Disaster Medical Care has adopted a model emergency plan for hospitals.

Originally developed by the Memorial Hospital of DuPage County, Elmhurst, the plan is recognized as a model by the Office of Defense Mobilization in Washington, D. C. Copies are available from the Society.

Medical Career Recruitment Programs

As man has advanced his life expectancy, it follows that many additional young men and women are and will be needed as members of the health team. Youth must be counseled early in their academic years in order to receive the proper educational background for a doctorate of medicine or allied health field degree.

The Woman's Auxiliary of the ISMS has been the spearhead force in Illinois to interest and recruit the youth of the state in medical careers. Members are asked to aid this effort by investigating the possibility of conducting or participating in career days in their home communities.

A paperback book entitled "Horizons Unlimited" is available from the Society.

SCIENTIFIC SPEAKERS BUREAU

The Illinois State Medical Society, through its Scientific Speakers Bureau, aids county societies in their efforts to keep members abreast of medical advances. Sponsored by the ISMS Committee on Continuing Education, the bureau helps local groups arrange and conduct postgraduate medical education programs in their own areas. This assistance includes obtaining speakers, helping them with travel arrangements, preparing and mailing notices of meetings, and paying an honorarium and travel expenses. ISMS can also provide publicity services upon request.

It also pays a \$50 honorarium and expenses for individual speakers obtained by county medical societies for their regular meetings.

The Bureau operates under a grant from Merck, Sharp & Dohme, which provides funds to the ISMS Educational and Scientific Foundation for the specific purpose of obtaining speakers for county medical society meetings.

The following procedures govern use of the Bureau:

- 1) County societies select speakers from a roster containing the names of more than 400 speakers and over 1,000 topics.

- 2) Eight weeks advance notice is required for postgraduate meetings. Requests for such meetings, which usually are scheduled for an entire afternoon, should be sent to the chairman of the Committee on Continuing Education, Illinois State Medical Society, 360 N. Michigan Ave., Chicago.

- 3) Publicity to media in the area of the meeting will be handled by ISMS upon request of the county society.

- 4) Postcard notices will be mailed to physicians in the county if requested. ISMS will prepare and mail notices if the information is received no less than three weeks prior to the meeting.

- 5) The county medical society program chairman and the speaker are both expected to submit to ISMS a report on the meeting and the arrangements.

PHYSICIANS PLACEMENT & STUDENT LOAN FUND PROGRAM

The Illinois State Medical Society not only offers help to students who wish to become physicians, but also is able to assist the careers of those already licensed to practice medicine.

The society provides this aid through two special activities. First is its own Physicians Placement Service. Second is the Illinois Medical Student Loan Fund Program that the society sponsors in conjunction with the Illinois Agricultural Association.

Physicians Placement Service

The Physicians Placement Service is designed to help physicians find a desirable area in which to establish practice or to relocate. The program's purpose is twofold, since it is interested also in helping those communities which demonstrate need of a resident physician.

More than 450 medical doctors have been placed through this program since its inception shortly after World War II.

The Physicians Placement Service maintains an up-to-date listing of some 150 "open" areas needing general practitioners. It maintains a similar listing of areas in need of specialists in a given field.

This service accepts requests from both physicians and communities for satisfactory placement. In addition, physicians are referred to the service by a number of organizations, among them the American Medical Association, the Illinois State Health Department and the Illinois Agricultural Association. Frequently, responsible citizens or

overburdened physicians in a community will contact the service.

Another important function of the Physicians Placement Service is to assist small communities in developing programs to attract physicians.

The Physicians Placement Service sends a questionnaire to the applicant physician to obtain information on his educational background, his interests and preferences of type of practice. Upon return of the questionnaire, the physician is sent a complete list of openings. Each opening is detailed on its facilities for home life, office space, proximity to hospital facilities and other specifics. The physician is also sent bulletins with information on new locations as they develop.

The Physicians Placement Service offers its assistance to all qualified physicians who request it. An applicant need not be a member of the state medical society. There is no charge either to the physician or to the community seeking the services of this program.

Illinois Medical Student Loan Fund Program

The Illinois Medical Student Loan Fund Program is designed to help those who have what it takes to become a physician but lack sufficient financial resources or a recommendation for medical school.

Loans to students in need are provided by joint contributions from the Illinois State Medical Society and the Illinois Agricultural Association. The program offers loans of \$750 per semester—up to a total of \$7,500 over a five-year period. A two per cent interest rate is charged semi-annually from the time the loan is received. The borrower must also insure himself for the entire amount of the loan and pay premiums on the policy. Repayment begins January 1 of the fifth year following medical school graduation.

The program also offers assistance to those who may not have financial difficulties but can't get into a "Class A" medical school because their college grades are marginal. The board representing the sponsoring organizations of the program can recommend 10 or more candidates annually to the University of Illinois College of Medicine in Chicago. After careful screening to determine whether the applicant has the potential to make a good medical student, the board can recommend him for admittance on the basis of its investigation.

In return for this assistance from the Medical Student Loan Fund Program, the applicant must

agree to practice medicine in an Illinois town—serving a rural population for five years. The applicant may select a town from an up-to-date list of communities which have demonstrated need and ability to support a physician, but choice is subject to approval by the program's board. The purpose of this agreement is to provide family doctors for the rural communities in Illinois.

To be considered for assistance from the Medical Student Loan Fund Program, an applicant must be recommended by the presidents of his home county medical society and farm bureau. Rules of eligibility require that an applicant be a premedical student of at least three years college standing . . . that he take a medical college admissions test, and that his college grade transcript be submitted with the completed application form. Illinois residency is not required.

The board of the Medical Student Loan Fund Program conducts its annual interview in January for those students who wish to enter medical school the following September. Those approved for assistance are accepted on a comparative and competitive basis. Information and applications may be obtained from Roy E. Will, secretary, Joint Medical Student Loan Fund Board, Illinois Agricultural Association, 1701 Towanda Ave., P.O. Box 901, Bloomington.

IMPARTIAL MEDICAL TESTIMONY

The Impartial Medical Testimony program, in which the Illinois State Medical Society participates, is designed to elicit objective medical truth and facilitate the equitable disposition of injury

cases in the courts of Illinois.

As a technique of judicial administration, impartial medical testimony examiners are ordered

by the court when there is evidence of a wide divergence of medical opinion in the injury which is subject to litigation. The introduction of the IMT examiner and subsequent examination of injuries provide the court with objective, impartial medical data for use in pre-trial conferences and in jury trials.

Authorization for the use of IMT examiners was established by the introduction of Illinois Supreme Court Rule 17-2 in September, 1961.

Illinois is distinguished in this matter by being the only state which has a court rule permitting the state-wide use of impartial medical testimony. The Illinois State Medical Society played a significant role in the creation and development of the IMT program. Impartial medical testimony in

other states is limited to certain jurisdictions within the states.

The Illinois State Medical Society panel of impartial medical examiners is comprised of approximately 250 physicians who are grouped into some 20 medical specialties. Composition of the panel is reviewed annually to maintain the highest standards for the courts of Illinois.

The Illinois State Medical Society is appreciative of its role in offering, in conjunction with the Supreme Court, impartial medical service for the courts of Illinois. The IMT Committee of the state society is charged with the responsibility of maintaining the IMT panel of qualified physicians, as required by the court.

INSURANCE PROGRAMS

Retirement Investment Program

The Board of Trustees of the Illinois State Medical Society has approved the *Retirement Investment Program* which makes available to members a means of providing for retirement with group advantages an individual physician could not otherwise obtain. The group annuity and mutual fund portion of the program may also be used as funding vehicles for Keogh qualified investment if so desired. The Tax Qualified Retirement Program (Keogh) and the Retirement Investment Program permit balanced investments to counter economic fluctuations.

Annuities or mutual funds alone do not meet the problems of recession and inflation, but together they do permit a sound retirement plan.

The group annuity provides a guaranteed lifetime income at retirement, serving as a hedge against periods of recession or declining prices, while the mutual fund provides an opportunity for common stock investment serving as a hedge against periods of inflation or rising prices.

A member physician wishing this type of retirement protection may obtain it through the Illinois State Medical Society. By doing, so he not only receives advantages he would not otherwise have, but he is able to benefit from the collective opinions and research facilities of the insurance company and the mutual fund's investment advisor.

The *Retirement Investment Program*, making available the group annuity at a substantial reduction in premium, and the mutual funds, offered without sales commission load, is one of the most recent of its kind and was developed after several years of study taking into consideration other group plans and retirement alternatives.

The size of the retirement contribution, the proportion of investment between the group annuity and the mutual fund, and the retirement age are determined by the participating physician.

The Continental Illinois National Bank and Trust Co. of Chicago receives all physicians' contributions, and maintains records.

Group Annuity

The group annuity, underwritten by the Continental Assurance Co., participates in dividends which are reinvested annually at compound interest.

The group annuity may provide an insurance death benefit and a total and permanent disability guarantee. In the event of death prior to retirement, a member's beneficiary would receive the death benefit or the cash value of the annuity, whichever is greater.

Six options for settlement at retirement are available under the annuity. The most frequently chosen is the life income option which guarantees a base income for life that can never be outlived. With the increase of life expectancy, there is a danger of depleting capital during advanced years. However, the group annuity assures, at least, a base or fixed income which cannot be outlived. Of equal importance is the fact that settlement may be arranged under the group annuity to guarantee at least a return of the member's investment to his beneficiary if he elects a life income and dies shortly after retirement.

Mutual Fund

The no load open end mutual fund, consisting primarily of common stocks, is managed by Stein Roe & Farnham of Chicago, which has been serving as investment adviser to pension and profit sharing trusts, trustees, individuals, and other investors since 1932.

The Stein Roe & Farnham Stock Fund is quoted daily in most major newspapers and the *Wall Street Journal*. The fund has no sales commissions. The investment adviser receives a quarterly management fee of $\frac{1}{8}$ of 1 per cent of the average net asset value of the fund. Management fees are common to all mutual funds and are distinct from sales loads.

Group Disability Program

The Illinois State Medical Society's officially approved *Group Disability Program* is available to all eligible members of ISMS up to age 70 who are regularly attending all of the usual duties of their occupation. Three different types of coverage are available under the program, with an over-70 conversion privilege.

Benefits of the program are payable regardless of any other insurance and no restrictive riders may be attached after issuance. The master contract contains a special renewal condition whereby the individual coverage cannot be terminated.

Provision has been made for an adjudication committee to advise the carrier on claims and other administrative problems. The adjudication committee will review the medical data and make recommendations regarding coverage which the insurance company might otherwise reject.

The program is explained in detail in a brochure which is available by writing to Parker, Aleshire & Co., 9933 Lawler Ave., Skokie 60076.

Group Major Medical Expense Plan

A \$25,000 *Group Major Medical Expense Plan* designed for the Illinois State Medical Society has a 20% co-insurance feature and a \$500 or \$1,000 deductible, whichever the physician selects. For hospital room and board, the Plan will pay up to \$50 a day and in addition up to \$45 a day in an intensive care unit. It will pay \$20 a day in a convalescent home following release from a hospital up to 90 days. The Plan also provides maximum coverage for the insured in the event of mental illness and up to \$2,000 for dependents. It will also cover a congenital anomaly from the first day of birth after the effective date of the contract up to \$2,000.

New members joining the Society will be allowed to enroll without evidence of insurability or a health statement under age 40 within six months after notification of the Plan's availability.

The Group Major Medical Expense Plan is outstanding and will provide members with protection against catastrophic illness.

The Plan is underwritten by the Commercial Insurance Co. of Newark, N.J., and is administered by Parker, Aleshire & Co., Skokie 60076. Addi-

tional information may be obtained from the Illinois State Medical Society.

Tax-Qualified Retirement Program

As mentioned above, the Board of Trustees has also approved the Society's *Tax-Qualified Retirement Program*, which utilizes a Continental Assurance Company Group Annuity and the Stein Roe & Farnham Stock Fund. This Program is intended for members who may find the provisions of the Keogh Act to their advantage. A recent liberalization, effective in 1968, which will allow contributions made by self-employed physicians to be fully deductible is expected to make this Program more attractive to the membership. The principal provisions of the Keogh Act are as follows:

1. A self-employed physician may set aside 10% of his net income from the practice of medicine or \$2,500.00 whichever is the lesser, each year for his own retirement.
2. A self-employed physician may deduct all of this amount from his income tax.
3. A self-employed physician must include all full-time employees with three or more years service under the Plan. A full-time employee is defined as an employee working twenty hours or more a week for a period of five or more months. The employee's contributions are made by the physician as a percent of salary at least equal to that percentage of net income put aside by the physician for his own retirement.
4. Funds invested under the Tax-Qualified Retirement Program accumulate tax free until distribution.

Continental Illinois National Bank & Trust Company of Chicago acts as Trustee for the Program's Annuity and Stock Fund shares and receives all physicians' contributions and maintains the Program's records.

Members wishing additional information on the Retirement Investment Program or its Keogh Act Program and the Tax-Qualified Retirement Program should write the Administrator for particulars: Paul H. Robinson, Jr., Incorporated, Administrator, ISMS Retirement Programs, 141 W. Jackson Blvd., Chicago 60604.

Professional Liability Program

An ISMS-Sponsored *Malpractice Liability Insurance Program* became available to members after it was approved by the Board of Trustees and the State of Illinois Insurance Department. All members may enroll in it at any time.

The Program was devised as an answer to the physician's complaints of arbitrary policy cancellations due to high risk specialty, age, abrupt increases in premium rates and headlong out of court settlements.

The underwriter of the program is Employers' Group of Insurance Companies, an 83 year old Boston firm. The administrator is Parker, Aleshire & Company, Skokie, which has served ISMS on other insurance plans since 1946.

Here are some key features of the program:

1. Coverage is available regardless of age, area in state in which member practices, or specialty.
2. ISMS directly supervises and controls the program, in conjunction with the administra-

tor and underwriter. No policy will be declined or cancelled without just cause and a review by an ISMS designee. Any proposals for premium rate increases or other changes will be submitted to the Insurance Committee for review and acceptance. Firm steps are being taken to improve the legal climate in Illinois. No claims will be settled without the written approval of the insured. Outstanding defense counsels, expert in malpractice cases, have been retained. The legal profession has been notified that every nuisance claim will be fought. An educational program emphasizes claim pre-

vention techniques and informs members of malpractice trends.

3. Coverage up to \$1,000,000 is available.

4. Premium rates are in line with those charged by other insurers. A unique premium saving feature makes the plan especially attractive to the member engaged in corporate practice. A better legal climate will help stabilize the rates because rates will reflect the loss experience as it occurs in Illinois.

Full details and application forms may be obtained from Parker, Aleshire & Company, 9933 North Lawler Avenue, Skokie, Illinois 60076 or by calling 312-679-1000.

RADIO-TV PUBLIC SERVICE MATERIALS

Radio materials available from the Illinois State Medical Society include:

- 1) "Today's Health Tip"—a new 30-second health message every day. Available on records (30 messages per record) which feature the voice of Dr. "SIMS." For added local appeal scripts are also available which can be read by local announcer or physician.
- 2) "Medicine, Morals and You"—an 11-part, half hour series combining a pre-taped dramatic introduction and live interviews with physicians and clergymen who discuss such vital medical-moral issues as: abortion, narcotics addiction, contraceptive pills, suicide, and the unwed mother.

Television materials currently include one-minute animated spots on the subjects of measles, arthritis quackery, pre-school examinations, and rheumatic fever. Subsequent spots stressing preventive medicine will be produced during the course of the year.

In addition, the Division of Public Relations maintains a radio and television speakers' bureau, which obtains physician-speakers for radio and television interview shows on request.

Doctor's Responsibility to the Press

Physicians and the press are partners in providing a line of communication between the medical profession and the public. But, the press cannot carry out its traditional responsibility in informing the public in the area of medical and patient news without the cooperation of the medical society and individual doctors. The inevitable penalty of silence by the doctors is public ignorance, misunderstanding and fear. In a democracy, public ignorance, misunderstanding and fear can be dangerous to professional freedom.

The following outline—based on a press code adopted by the Macon County Medical Society—is suggested as a pilot guide for individual physicians and county societies in Illinois.

Availability

1) The officers, committee chairmen or designated spokesmen of county medical societies shall be available at all times to mass media personnel to provide authentic information on medical subjects.

2) A list of current spokesmen shall be supplied by county societies to the executives of every newspaper, radio and television station in the county.

3) These spokesmen may be quoted by name. They should not be considered by their colleagues as self-seeking, since authoritative attribution is done in the best interests of the public and the profession. (In addition, physicians are private citizens and as such are the subjects of news stories in their social and civic activities just like any other citizen.)

Physician News

Physicians, as scientists, are encouraged to give newspaper interviews and appear on radio and television programs on medical subjects. Physicians may report on new or unusual diseases or treatments within an ethical framework. In these instances, they should, whenever possible, notify their county society publicity chairman or the Illinois State Medical Society.

Physicians may be asked to comment as individuals on politically controversial subjects (such as socialized medicine). In this event, the physician should clearly indicate that he is expressing his personal viewpoint which should not be construed as a statement of medical society policy.

A medical society officer, however, should remember that any comment he makes—whether or not intended as personal viewpoint—is generally accepted as official policy.

Patient News

As the patient's personal physician, the doctor has an obligation to respect confidences that come to him in the performance of his duty and may

not release news except with the patient's consent or those authorized to speak for him. When the press learns of the illness of private patients from other sources, the physician may cooperate with the press in answering any inquiries in the interest of accuracy and to avoid embarrassment.

When news of patients is of such a nature that it automatically falls in the public domain, physicians should feel free to release information within the framework of this code.

Patient information may be given where the nature of injuries, illness or treatment is of special interest. The report of such information shall be more in the nature of scientific information, rather than an exposé of an individual affliction.

Pre-Retirement TV and Film Series

Recognizing the current "retirement revolution"

in which persons are retiring earlier and living longer, the ISMS Committee on Aging recently produced a 13-part, half hour weekly television series on pre-retirement planning entitled, "The Time Of Your Life."

The series—co-sponsored through a grant from Blue Shield Plan of Illinois Medical Service—features broadcast personality Norman Ross who interviews guest authorities on such vital topics as: financial and estate planning; meeting medical expenses; where to live in retirement; how to cope with physical and emotional problems; and constructive utilization of leisure time. Initially shown on Chicago television, the series is now available for loan on 16 mm. film to industries, businesses, and other organizations throughout the state and nation as a "ready made" course of instruction.

Illinois Medical Political Action Committee (IMPAC)

The Illinois Medical Political Action Committee (IMPAC) is a voluntary, non-profit, unincorporated, permanent membership organization founded in 1960. IMPAC serves as the unified political action arm of Illinois physicians and their wives. It cooperates with others in the healing arts professions. Funds collected through IMPAC memberships, used in support of candidates, are administered independently of other professional groups. However, the program is operated in harmony with the legislative objectives of the Illinois State Medical Society. Individual participation in IMPAC is one means by which the individual physician and his wife can effectively participate in public affairs.

IMPAC participates primarily in election contests for legislative offices—both those in the Illinois General Assembly and in the U. S. Con-

gress. It cooperates, both in election efforts and in membership solicitation activities, with the American Medical Political Action Committee (AMPAC), its counterpart on the national level.

IMPAC's organization consists of a chairman, an executive committee, and a council. Political action activities are implemented by local physician support committees formed on behalf of candidates in U. S. Congressional or other legislative districts. Candidate selection and support are determined on the basis of evaluations and recommendations submitted to the council and executive committee by the local committees, thus assuring members of a "grass roots" voice in IMPAC activities.

Additional information about IMPAC may be obtained by writing: IMPAC, Suite 2010, 360 N. Michigan Ave., Chicago 60601.

Woman's Auxiliary To The Illinois State Medical Society

The new auxiliary year could not have begun on a higher note than with the enthusiasm and fellowship exhibited here over the past few days.

On behalf of the newly elected officers may I say that we are delighted, honored and sincerely grateful for the confidence you have placed in our ability to carry out the work of the Women's Auxiliary to the Illinois State Medical Society during the coming year. However, we

are well aware that shoulder to shoulder with honor always walks responsibility.

Like happiness, success is one of the fundamental goals of all people, and, of course, we want success for this administration's goals just as has been true of all previous ones.

To carry through your expectations, we must have the cooperation and assistance of not only each District

and each County auxiliary, but also that of each individual member. In the final analysis, it is the individual member who is the power behind the Auxiliary.

To uphold the proud heritage of the AMA Woman's Auxiliary, we, in Illinois, must maintain ourselves as a first rate organization. In the year ahead, we hope to see county auxiliaries throughout the State develop to their highest possible strength and efficiency so they may be able to accomplish the greatest amount of good.

It seems that we could be motivated by no wiser philosophy than was expressed by the prophets of old who believed that we cannot pass along to others the accountability for situations and conditions in our homes or communities. We must face up to these—bear the burdens and do what we can to resolve them.

This, too, is the essence of the theme your president has selected for Illinois in 1970-71. Our State theme will stress the importance of the "Fourth 'R'"—RESPONSIBILITY with special emphasis on INDIVIDUAL RESPONSIBILITY.

It wasn't "the three Rs" that made this country the greatest in the world.

George Washington's schooling would not have admitted him to the University of Illinois.

Benjamin Franklin's formal education did not go beyond two years.

James Madison and Alexander Hamilton were officers fighting in the Revolutionary War at an age when the youth of today are packing their bags getting ready to go away to college.

But what these men did have was a thorough grounding in that all important "Fourth 'R'"—Responsibility!

As individuals we have the responsibility to think and act wisely today so that tomorrow will be a better day. We are told there are two ways to approach a responsibility . . . with reluctance or with enthusiasm.

A famous writer once said, "Every tomorrow has two handles. You can take hold of tomorrow with the handle of Anxiety or you can take hold of it with the handle of Faith."

Concerned about the moral climate of our nation, county auxiliaries in Illinois towns, rural areas and cities demonstrated in yesterday's annual reports that they had indeed taken hold of the handle of Faith.

Their many voices told how positive thinking and determined action had resulted in effective health-education programs. Their voices spoke eloquently of projects that have gained \$11,000 for AMA-ERF, an all time high for Illinois.

That Miracles can be performed by mobilizing Woman Power is illustrated in the story concerning a county auxiliary president who died suddenly and there was no room for her in Heaven . . . so she was sent to the regions below. Two days later Satan called up and asked that she be removed immediately! "What's wrong?" asked St. Peter. She seemed to be a very nice lady. I'll tell you what's wrong stormed Satan." She has organized a group of women down here and they have raised enough money to install air conditioning!"

In charting the course for the year ahead, Mrs. R. C. L. Robertson, national president-elect, stated in her address yesterday that the following guide lines have been established:

1. AMA-ERF and Health Man-Power are to be considered Top Priority Projects.
2. Physical Fitness of Doctors' families (as well as the public) will be highlighted.
3. Strongly encouraged are Health Education Programs concerning Drug Abuse, Alcoholism or any one of the eleven Package Programs which are ready and waiting your consideration.

We cannot afford to overlook our Responsibility of taking a part in helping to care for the aged and the handicapped. The Home-Care Project, one of the most vital of auxiliary services may be compared to the parable of "The Most Precious Gem." The parable tells of a man who could not enter the Pearly Gates except that he bring earth's most precious possession . . . so he searched the earth trying. First, Gold as a symbol of Wealth; then, The Sword of Alexander The Great as a symbol of Conquest; next, The Books of Solomon as a symbol of Wisdom. All were turned down by the Guardian Angel. Again the man returned to earth . . . finding nothing he resolved to return and confess his failure to the Guardian Angel. On the way he befriended a poor, broken beggar and when he reached the Pearly Gates his cheeks were marked with tears of sympathy. "You have brought it!" cried the Guardian Angel. You have brought Earth's most precious thing, "The Priceless Pearl of Compassion."

In working together as responsible adults, let us strive for excellence in the promotion of health education in our communities. Best of all let us develop a team spirit . . . for auxiliary work is truly the finest type of partnership. In this togetherness lies our power of achievement.

Perhaps you may recall this occurrence which took place in the Olympic Games a number of years ago. The French Team started well in the relay race and was in the lead when one of the runners dropped the baton as it was being passed to him by a teammate. This put the French team out of the running and lost the race for them. The player responsible sank to the ground and wept openly. Those who watched understood his despair when so many others were affected by his failure. His country's high hopes for victory had been lost. The training and efforts of those who had run before him were nullified. Worst of all the runner that was to follow did not even get a chance to run.

Today, we stand on the threshold of a new auxiliary year. The baton is now being passed to this administration. With the willing hands of Illinois' approximately three thousand members, we cannot fail to carry it through to the successful accomplishment of our goals.

Mrs. Wilson H. West
President

OFFICERS

PRESIDENT: Mrs. Wilson H. West,

14 Oakwood Drive, Belleville 62223

PRESIDENT-ELECT: Mrs. David Kweder

1432 N. Sheridan Rd., Waukegan 60085

VICE-PRESIDENT: Mrs. Robert Hartman

1040 W. College, Jacksonville 62650

VICE-PRESIDENT: Mrs. August Martinucci

1210 Mason, Joliet 60435

VICE-PRESIDENT: Mrs. Joseph A. Cari

9212 S. Mozart, Evergreen Park 60642

RECORDING SECRETARY: Mrs. Thomas Tourlentes

State Research Hospital, Galesburg 61401

CORRESPONDING SECRETARY: Mrs. Edward Szewczyk

1 Kilmar Woods, Belleville 62224

TREASURER: Mrs. Gaetano Buttice

266 Stonegate Rd., Clarendon Hills 60514

DIRECTORS

Mrs. Sherman Arnold
2416 Brookwood Drive, Flossmoor 60422
Mrs. Howard Lowy
112 Pekin Ave., East Peoria 61611
Mrs. Lewis A. Hare
10811 S. Fairfield Ave., Chicago 60655

DISTRICT COUNCILORS

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| <p>1. Boone, DeKalb, Jo Daviess, Kane, Lake, Stephenson, Winnebago.
Mrs. Norm Hagman
5059 Crofton, Rockford</p> <p>2. Bureau, LaSalle, Lee, Livingston, Whiteside
Mrs. W. A. McNichols, Jr.
912 Myrtle Avenue, Dixon 61020</p> <p>3. Cook
Mrs. Harold Dubner
910 Private Rd., Winnetka 60093
Mrs. Jan J. Kukral
860 N. Lake Shore Dr., Chicago 60611
Mrs. John Van Prohaska
5830 Stony Island, Chicago 60637</p> <p>4. Knox, Mercer, Peoria, Rock Island, Warren
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1218-21st Ave., Rock Island 61201</p> <p>5. Logan, McLean, Sangamon, Tazewell
Mrs. Frank Torrey
1331 Center St., Pekin 61554</p> | <p>6. Adams, Madison, Morgan-Scott
Mrs. Ralph F. Davis
2639 Vermont, Quincy 62301</p> <p>7. Christian, Effingham, Macon, Marion-Clinton
Mrs. Wilmer Talbert
316 North Summit, Decatur 62522</p> <p>8. Champaign, Crawford, Vermillion
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1202 Belmead, Champaign 61820</p> <p>9. Jefferson-Hamilton
Mrs. Cyril Anslinger
26 Northbrook, Mt. Vernon 62864</p> <p>10. St. Clair, St. Clair-Belleville Branch, Jackson
Mrs. C. B. Boeshart
42 Magnolia Dr., Belleville 62221</p> <p>11. DuPage, Kankakee, Will-Grundy
Mrs. James Ryan
Woodlea Road Box 14, Kankakee 60901</p> |
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1000 S. Wildwood Ave., Kankakee 60901</p> <p>Archives Mrs. Walter Olsewski
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1040 W. College, Jacksonville 62650</p> <p>Convention Mrs. Mitchell Spellberg
1212 N. Lake Shore Dr., Chicago 60610</p> <p>Vice Chairman Mrs. Eugene Vickery
602 Oak Street, Lena 61048</p> <p>Credentials & Regis. Mrs. John Ovitz
427 S. Maine, Sycamore 60178</p> <p>Editorial (Pulse) Mrs. Wendell Roller
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159 S. 9th Street, East Alton 62024</p> <p>Hospitality Mrs. John Koenig
2518 Oakwood Dr., Olympia Fields 60461</p> <p>Vice Chairman Mrs. Maurice Goldstein
6853 North Hiawatha, Chicago 60646</p> | <p>Vice Chairman Mrs. C. R. Heidenreich
20313 Kedzie, Olympia Fields 60461</p> <p>International Health Mrs. R. S. Hoover
1752 Highland Drive, Freeport 61032</p> <p>Legislation Mrs. Alan Taylor
1607 N. Vermilion, Danville 61832</p> <p>Members-at-Large Mrs. O. E. Barbour
4119 Hollyridge Cr., Peoria 61614</p> <p>Mental Health Mrs. Michael J. Parenti
1039 Lathrop, River Forest 60305</p> <p>Organization Mrs. David Kweder
1432 N. Sheridan Rd., Waukegan 60085</p> <p>Press & Publicity Mrs. Leslie Lindeen
801 Stevens Ave., Sycamore 60178</p> <p>Program Mrs. Joseph A. Cari
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25 High Forest, Belleville 62221</p> <p>Revisions and Resolutions Mrs. Joseph Shanks
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Hardin 62047</p> <p>Safety Mrs. Arthur Smith
206 Country Club Lane, Belleville 62223</p> <p>WASAMA Mrs. G. F. Tufo
750 West Hutchinson, Chicago 60613</p> |
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AD HOC COMMITTEES

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10 Connecticut Ct., Springfield 62704	
Vice Chairman	Mrs. Stanley Burris
1630 Wiggins, Springfield 62704	
Religion & Medicine	Mrs. Sherman Arnold
2416 Brookwood Drive, Flossmoor 60422	
Parliamentarian	Mrs. Percy M. Clark
5722 Franklin Ave., LaGrange 60525	

Illinois Medical Assistants Association

The Illinois Medical Assistants Association is just what the name implies—an association of medical assistants throughout the State of Illinois who have become an educational organization with objectives as follows: (a) To bring into one association all medical assistant organizations of the State of Illinois; (b) to provide an organization for those residing in Illinois counties where no medical assistants societies are organized; (c) to assist the physicians in improving medical public relations; (d) to maintain and advance the standards of professional employment and to give honest, loyal and efficient service to the medical profession and the public; (e) to meet from time to time to secure interchange of ideas.

The medical assistant associations are educational groups—not social. *We are not a union and any attempt to promote the unionization of this society or its members automatically forfeits the membership of the person or persons making such an attempt.*

Now the qualified medical assistant has the opportunity to pass a special board examination and thus become a “Certified Medical Assistant.”

This will affect directly or indirectly every physician's office. Of note is the fact that you do not have to belong to the Association to take this examination. For further information as to qualifications necessary to take the examination write to American Association of Medical Assistants, 200 E. Ohio St., Chicago 60611.

Local programs in the component societies of IMAA are geared to the needs of that particular area. Obviously the strictly specialist areas would have entirely different problems and educational needs than the area of the general practitioner where the office is staffed by one or two medical assistants. Hence the educational programs in your area would be decided by your own medical assistants and supervised by the doctors in your own county society.

We need you, Doctor, to encourage your medical assistants to join our association. But also you could help us by assisting us in selecting the proper educational programs which in the long run would be of most benefit to you. That is our whole purpose, to become better medical assistants so we can help you to help your patients.

Medical and Paramedical Education

MEDICAL SCHOOLS IN THE STATE OF ILLINOIS

Chicago Medical School
2020 W. Ogden Ave.
Chicago, Illinois 60612

Northwestern University Medical School
303 E. Chicago Ave.
Chicago, Illinois 60611

University of Chicago Pritzker School of Medicine
950 E. 59th Street
Chicago, Illinois 60637
University of Illinois College of Medicine
1853 W. Polk Street
P.O. Box 6998
Chicago, Illinois 60680

Stritch School of Medicine—Loyola University
2160 S. First Ave.
Maywood, Illinois 60153

The following are medical schools in Illinois which are presently in the developmental stages. The names used are not necessarily correct.

Rush Medical College
Chicago, Illinois
Anticipates enrollment to begin in 1971

Southern Illinois University Medical School
Carbondale, Illinois
Anticipates enrollment to begin in 1972

University of Illinois—The Abe Lincoln Campus
Peoria—Rockford, Illinois
Anticipates enrollment to begin in 1972

APPROVED SCHOOL FOR MEDICAL RECORD LIBRARIANS

CHICAGO—University of Illinois at the Medical Center

APPROVED SCHOOL OF PHYSICAL THERAPY

CHICAGO—Northwestern University Medical School

APPROVED COURSE IN OCCUPATIONAL THERAPY

CHICAGO—University of Illinois—School of Associated Medical Service

APPROVED SCHOOLS OF INHALATION THERAPY

CHICAGO—Cook County Hospital, Edgewater Hospital, Northwestern University Medical Center, Rush-Presbyterian-St. Luke's Hospital, University of Chicago Hospitals

DECATUR—St. Mary's Hospital

MELROSE PARK—Gottlieb Memorial Hospital

MOLINE—Lutheran Hospital

SPRINGFIELD—Memorial Hospital, St. John's Hospital

APPROVED SCHOOLS OF CERTIFIED LABORATORY ASSISTANTS

ALTON—Alton Memorial Hospital

ARLINGTON HEIGHTS—Northwest Community Hospital

CHICAGO—St. Elizabeth Hospital, Swedish Covenant Hospital, Veterans Administration West Side Hospital

CRYSTAL LAKE—McHenry County College

DANVILLE—St. Elizabeth Hospital

DIXON—Sauk Valley College, Dixon Public Hospital

ELGIN—Sherman Hospital

OAK PARK—Oak Park Hospital

PALOS HILLS—Moraine Valley Community College

QUINCY—Blessing Hospital

APPROVED SCHOOLS OF CYTOTECHNOLOGY

CHICAGO—Michael Reese Medical Center, Mount Sinai Medical Center, University of Chicago Hospitals and Clinics

APPROVED SCHOOLS OF MEDICAL TECHNOLOGY

AURORA—Copley Memorial Hospital
 BELLEVILLE—St. Elizabeth Hospital
 BLUE ISLAND—St. Francis Hospital
 CHAMPAIGN—Burnham City Hospital
 CHICAGO—Augustana Hospital, Chicago Wesley Memorial Hospital, Edgewater Hospital, Grant Hospital of Chicago, Holy Cross Hospital, Illinois Masonic Medical Center, Louis A. Weiss Memorial Hospital, Mercy Hospital, Michael Reese Hospital and Medical Center, Mount Sinai Hospital Medical Center, Northwestern University Medical School, Presbyterian-St. Luke's Hospital, St. Anne's Hospital, St. Anthony's Hospital, St. Joseph Hospital, St. Mary of Nazareth Hospital, University of Illinois School of Associated Medical Sciences and Veterans Administration Research Hospital.
 CHICAGO HEIGHTS—St. James Hospital
 DANVILLE—Lake View Memorial Hospital
 DECATUR—Decatur Memorial Hospital and St. Mary's Hospital
 ELK GROVE VILLAGE—St. Alexius Hospital

EVANSTON—Evanston Hospital
 St. Francis Hospital
 EVERGREEN PARK—Little Company of Mary Hospital
 FREEPORT—Freeport Memorial Hospital
 GENEVA—Community Hospital
 GREAT LAKES—U.S. Naval Hospital
 HARVEY—Ingalls Memorial Hospital
 HINSDALE—Hinsdale Sanitarium and Hospital
 JOLIET—Silver Cross Hospital
 St. Joseph Hospital
 MAYWOOD—Loyola University Center
 OAK LAWN—Christ Community Hospital
 OAK PARK—West Suburban Hospital
 PARK RIDGE—Lutheran General Hospital
 PEORIA—Methodist Hospital of Central Illinois and St. Francis Hospital
 QUINCY—St. Mary's Hospital
 ROCKFORD—Rockford Memorial Hospital, St. Anthony Hospital and Swedish-American Hospital
 SPRINGFIELD—Memorial Hospital
 St. John's Hospital
 URBANA—Carle Foundation Hospital
 WAUKEGAN—St. Therese's Hospital
 WINFIELD—Central Dupage Hospital

APPROVED SCHOOLS OF X-RAY TECHNOLOGY

ARLINGTON HTS.—Northwest Community Hospital
 AURORA—Copley Memorial Hospital
 St. Joseph Mercy Hospital
 BLOOMINGTON—Bloomington-Normal Hospital
 CENTRALIA—St. Mary's Hospital
 CHAMPAIGN—Burnham City Hospital
 CHICAGO—Chicago Wesley Memorial Hospital
 Cook County Hospital
 Edgewater Hospital
 Englewood Hospital
 Franklin Boulevard Community Hospital
 Henrotin Hospital
 Illinois Masonic Medical Center
 Louis A. Weiss Memorial Hospital
 Michael Reese Hospital and Medical Center
 Mt. Sinai Hospital and Medical Center
 Norwegian-American Hospital
 Provident Hospital
 Ravenswood Hospital
 Roseland Community Hospital
 Rush-Presbyterian-St. Luke's Hospital
 St. Anne's Hospital
 St. Bernard's Hospital
 St. Joseph Hospital
 St. Mary of Nazareth Hospital
 South Chicago Community Hospital
 Sydney R. Forkosh Memorial Hospital
 Woodlawn Hospital
 DANVILLE—Lake View Memorial Hospital
 DECATUR—Decatur Memorial Hospital
 DEKALB—DeKalb Public Hospital
 DIXON—Sauk Valley College
 EAST ST. LOUIS—Centreville Township Hospital
 ELGIN—St. Joseph Hospital
 ELMHURST—Memorial Hospital of DuPage County

EVANSTON—St. Francis Hospital
 Evanston Hospital
 EVERGREEN PARK—Little Company of Mary Hospital
 GALESBURG—Carl Sandburg College
 GLEN ELLYN—College of DuPage
 GREAT LAKES—U.S. Naval Hospital
 HARVEY—Thorton Community College
 HINES—Veterans Administration Hospital
 HINSDALE—Hinsdale Sanitarium and Hospital
 JOLIET—Silver Cross Hospital
 St. Joseph Hospital
 KANKAKEE—St. Mary's Hospital
 KEWANEE—Kewanee Public Hospital
 MOLINE—Lutheran Hospital
 Moline Public Hospital
 OAK PARK—West Suburban Hospital
 OLNEY—Richland Memorial Hospital
 PARK RIDGE—Lutheran General Hospital
 PEORIA—Methodist Hospital of Central Illinois
 St. Francis Hospital
 QUINCY—Blessing Hospital
 St. Mary Hospital
 RIVERGROVE—Triton College
 ROCHELLE—Rochelle Community Hospital
 ROCKFORD—Rockford Memorial Hospital
 St. Anthony Hospital
 Swedish-American Hospital
 ROCK ISLAND—St. Anthony's Hospital
 SKOKIE—Skokie Valley Community Hospital
 SPRINGFIELD—Memorial Hospital
 St. John's Hospital
 SYCAMORE—Kishwaukee Junior College
 URBANA—Carle Memorial Hospital
 Mercy Hospital

APPROVED SCHOOLS OF NURSING

Associate Degree Nursing Program

A coeducational nursing program under the auspices of a junior college, two years in length and leading to an Associate Degree in Nursing. The curriculum consists of arts and sciences at the junior college level and nursing theory closely coordinated with nursing practice, under direction and supervision of the college faculty, in community hospitals and health facilities.

Graduates, both men and women, are prepared to give patient-centered care in staff nurse positions in hospitals, nursing homes and similar situations. They are prepared to cooperate and to share responsibility for the patient's welfare with other members of the nursing and health staff, and to develop their own skills through experience as practicing nurses.

BELLEVILLE

Belleville Area College
Department of Nursing
2555 West Blvd. 62221

CHICAGO

Amundsen-Mayfair Junior College
Department of Nursing
4626 N. Knox Ave. 60630

Malcolm X. College
Department of Nursing
1757 W. Harrison 60612

Southeast College School of Nursing
8600 South Anthony 60617

CHICAGO HEIGHTS

Prairie State College
Department of Nursing
197th & Halsted 60411

CHAMPAIGN

Parkland College School of Nursing
2 Main Street 61820

CICERO

J. Sterling Morton Junior College
Department of Nursing
2423 S. Austin Blvd. 60650

DIXON

Sauk Valley College School of Nursing
River Campus, R.R. #1 61021

EAST PEORIA

Illinois Central College
Department of Nursing
Highview Road,
P. O. Box 2400 61611

ELGIN

Elgin Community College
Department of Nursing
373 E. Chicago St. 60120

GLEN ELLYN

College of DuPage
Department of Nursing
22nd & Lambert Road 60137

GRAYSLAKE

General Entrance Requirements:

Good health.

High school graduation: with courses in biological and physical sciences (1-2 units of chemistry recommended) and mathematics (1-2 units recommended).

Qualification for admission to the college and the nursing curriculum.

Cost: tuition in public supported junior colleges is low, in private colleges considerably higher. Add to this: fees, books, uniforms and maintenance.

Living Arrangements: students live at home, in a college dormitory or other approved residence.

Graduate is eligible to take the state examination for licensure as a registered nurse ("R.N.").

College of Lake County
Department of Nursing
19351 West Washington 60030

HARVEY

Thornton Community College
Department of Nursing
151st St. & Broadway 60164

JOLIET

Joliet Junior College
201 E. Jefferson 60432

KANKAKEE

Kankakee Community College
Department of Nursing
River Road 60901

MOLINE

Black Hawk College
Department of Nursing
1001 Sixteenth St. 61265

NORTHLAKE

Triton College
Department of Nursing
1000 Wolf Rd. 60164

OGLESBY

Illinois Valley Community College
Department of Nursing
R.R. #1 61348

OLNEY

Olney Central College
305 N. West St. 62450

PALATINE

William Rainey Harper College
Department of Nursing
Algonquin & Roselle Roads 60067

RIVER GROVE

Triton College
Department of Nursing
2000 Fifth Avenue 60171

ROCKFORD

Rock Valley College
Associate Degree Nursing Program
3301 N. Mulford Rd. 61111

Associate Degree Programs Now Being Developed

CHICAGO

Kennedy-King College
Department of Nursing
7047 South Stewart Ave
Chicago 60621

SUGAR GROVE

Waubensee College
Department of Nursing
Illinois Route #47 & Harper Road
Sugar Grove 60554

GALESBURG

Carl Sandburg College
Department of Nursing
139 South Cherry Street
Galesburg 61401

Baccalaureate Degree Nursing Program

Usually a coeducational nursing program under the auspices of a college or university, this is generally four academic or calendar years in length. The curriculum combines general education with nursing education, leading to the Bachelor of Science Degree in Nursing. Liberal education courses, such as arts and sciences, are shared with all college students. University medical centers and other related hospital and community health agencies are utilized for nursing theory and practice.

Graduates, both men and women, are prepared for beginning nursing positions in hospitals, nursing homes and community health services, and for advancement without further formal education to positions such as "nursing team" leader or head nurse. They also have the foundations for continuing personal and professional development and for graduate study and specialization in nursing.

BLOOMINGTON

Illinois Wesleyan University
Brokaw Collegiate School of
Nursing 61701

CHICAGO

DePaul University
Department of Nursing
25 E. Jackson Blvd. 60604
Loyola University
School of Nursing
6526 N. Sheridan Rd. 60626
North Park College
Department of Nursing
5125 N. Spaulding Ave. 60625

General Entrance Requirements:

Good health.

High school graduation: college preparatory program including biology and physical sciences (1-2 units of chemistry recommended) and mathematics (1-2 units). Two years of a foreign language may be required. Meets college or university admission standards.

Cost: college or university tuition fees for nursing programs are comparable to those for other majors. Range in Illinois is from approximately \$1,000 to \$7,000 for tuition and fees for total program. Other expenses: books, uniforms, maintenance.

Living Arrangements: students live at home, in a college dormitory or other approved residence.

Graduate is eligible to take state examination for licensure as a registered nurse ("R.N.").

St. Xavier College
School of Nursing
103rd & Central Park 60655

University of Illinois
College of Nursing
P.O. Box 6998
845 S. Damen 60612

DEKALB

Northern Illinois University
School of Nursing 60115

EDWARDSVILLE

Southern Illinois University
Edwardsville Campus
Department of Nursing 62025

KANKAKEE

Olivet Nazarene College
Department of Nursing 60901

PEORIA

Bradley University
Department of Nursing 61606

Diploma (Hospital) Nursing Program

A nursing program under the auspices of a hospital or independent school of nursing, two to three years in length, and leading to a Diploma in Nursing. A college or university may provide some of the courses. The curriculum consists of theory and practice focused primarily on instruction and related clinical experience in the nursing care of patients in hospitals. Some liberal arts courses may be included.

Graduates, both men and women, have the understanding and skills necessary to organize and implement a plan of nursing that will meet the immediate needs of one or more patients and that will promote the restoration of health. They are also able to plan with associated health personnel for the care of patients, and may be

responsible for the direction of other members of the nursing team.

General Entrance Requirements:

Good health.

High school graduation: Usually upper half of class, with courses in biological and physical sciences (1-2 units, one of which should be chemistry) and mathematics (1-2 units).

Satisfactory results on entrance tests and qualification for admission to the school.

Cost: \$900 to \$3,500; some include full maintenance.

Living Arrangements: Schools have residence facilities; many permit students to live at home if preferred.

Graduate is eligible to take the state examination for licensure as a registered nurse ("R.N.").

ALTON

Alton Memorial Hospital
Memorial Drive 62002
St. Joseph's School
915 E. Fifth St. 62004

AURORA

Copley Hospital
Lincoln & Weston 60507

BLOOMINGTON

Mennonite Hospital
804 N. East Main 61701

CANTON

Graham Hospital
210 W. Walnut St. 61520

CHAMPAIGN

Burnham City Hospital
404 S. Third St. 61822

CHICAGO

Augustana Hospital
411 Dickens Ave. 60614
Chicago Wesley Memorial Hospital
250 E. Superior St. 60611
Cook County Hospital
1900 W. Polk St. 60612
Illinois Masonic Hospital
836 Wellington Ave. 60657
James Ward Thorne—
Passavant Memorial Hospital
244 East Pearson St. 60611
Michael Reese Hospital and Medical Center
2816 S. Ellis Ave. 60616
Mount Sinai Hospital & Medical Center
2730 W. 15th Place 60608
Ravenswood Hospital & Medical Center
1931 W. Wilson Ave. 60640
St. Anne's Hospital
4950 W. Thomas St. 60651
St. Bernard's Hospital
6344 S. Harvard Ave. 60621
St. Mary of Nazareth Hospital
1127 N. Oakley Blvd. 60622
South Chicago Community Hospital
2320 E. 93rd St. 60617

DANVILLE

Lake View Memorial Hospital
812 N. Logan Ave. 61833

DECATUR

Decatur Memorial Hospital
2300 N. Edward St. 62526

EVANSTON

Evanston Hospital
2645 Girard Ave. 60201
St. Francis Hospital
319 Ridge Ave. 60202

FREEPORT

Freeport Memorial Hospital
1133 W. Stephenson 61032

GALESBURG

Galesburg Cottage Hospital
674 N. Seminary Ave. 61401

JACKSONVILLE

Passavant Memorial Area Hospital
1600 W. Walnut St. 62650

JOLIET

St. Joseph Hospital
333 N. Madison St. 60435

MOLINE

Lutheran Hospital
555 Sixth St. 61265
Moline Public Hospital
635 Tenth Avenue 61265

OAK LAWN

Evangelical (Christ Community Hospital)
4440 W. 95th St. 60453

OAK PARK

West Suburban Hospital
518 N. Austin Blvd. 60302

PARK RIDGE

Lutheran General and Deaconess Hospital
1700 Western Ave. 60068

PEORIA

Methodist Hospital of Central Illinois
221 N.E. Glen Oak 61603
St. Francis Hospital
211 Greenleaf St. 61603

QUINCY		
Blessing Hospital		
1005 Broadway	62301	
ROCKFORD		
Rockford Memorial Hospital		
2400 N. Rockton Ave.	61103	
St. Anthony Hospital		
5666 E. State St.	61101	
Swedish-American Hospital		
1316 Charles St.	61101	

ROCK ISLAND		
St. Anthony Hospital		
767 Thirtieth St.	61201	
SPRINGFIELD		
Memorial Hospital		
200 N. Dodge St.	62701	
St. John's Hospital		
401 N. Ninth St.	62701	

Practical Nursing Program

A coeducational nursing program under the auspices of public vocational education systems, hospitals or community agencies, usually one year in length. The curriculum includes nursing theory coordinated with nursing practice.

Graduates, both men and women, of programs in practical nursing are prepared for two roles:

Entrance Requirements:

Good health.

High school: Two years minimum, graduation desirable. Junior and senior students who are currently enrolled in high school are eligible to enroll in the practical nursing program as part of their credit curriculum.

Satisfactory results on entrance tests.

References and personal interview.

Cost: None under MDTA programs, to approximately \$400 plus maintenance.

Living Arrangements: Students usually live at home or in housing approved by school.

Graduate is eligible to take the state examination for licensure as a practical nurse ("L.P.N.").

ALTON		
F. W. Olin School of Practical Nursing		
2512 Amelia Street	62002	
BLOOMINGTON		
Bloomington School of Practical Nursing		
709 S. Clinton St.	61701	
CAIRO		
Cairo School of Practical Nursing		
1615 Commercial Street	62914	
CARBONDALE		
Southern Illinois University Vocational Technical Institute of Practical Nursing	62901	
CHAMPAIGN		
Champaign School of Practical Nursing		
103 N. Prospect Ave.	61821	
CHICAGO		
Chicago Public Schools Practical Nursing Center		
1820 W. Grenshaw	60612	
Chicago Public Schools Licensed Practical Nurses Program, Manpower Division		
2913 N. Commonwealth	60657	
St. Frances X. Cabrini School of Practical Nursing		
811 S. Lytle St.	60607	

(1) under the supervision of a professional nurse or physician, they give nursing care to patients in situations relatively free of scientific complexity; (2) in a close working relationship, they assist the professional nurse in giving care to patients requiring a high degree of nursing skill and judgment.

DANVILLE		
Danville School of Practical Nursing		
305 W. Madison St.	61833	
DECATUR		
Decatur School of Practical Nursing		
210 W. North St.	62522	
DES PLAINES		
Niles Township H. S. School of Practical Nursing		
Oakton & Edens Expressway	60018	
DIXON		
Sauk Valley College		
River Campus Route #1	61021	
EAST PEORIA		
Illinois Central College Practical Nursing Program, Health Education		
3202 N. Wisconsin	61603	
EAST ST. LOUIS		
School of Practical Nursing		
905 Ohio St.	62205	
GALESBURG		
Carl Sandburg College, Department of Practical Nursing		
Box 1407, South Lake Storey Road	61401	
Galesburg Practical Nurse Program		
650 Locust St.	61401	
HARRISBURG		
Southeastern Illinois College, School of Practical Nursing		
333 W. College St.	62946	
HINSDALE		
Hinsdale Hospital School of Practical Nursing		
120 N. Oak St.	60521	
JACKSONVILLE		
Jacksonville Board of Education School of Practical Nursing		
504 E. Court St.	62650	
JOLIET		
Joliet Township H.S. School of Practical Nursing		
201 E. Jefferson St.	60432	

KANKAKEE Kankakee School of Practical Nursing 293 E. Court St. 60901	PALATINE William Rainey Harper Practical Nurse Program Algonquin & Roselle Roads 60067
KARNAK Shawnee Community College Practical Nursing Program 206 E. First, P.O. Box 237 62956	PEKIN Pekin Practical Nurse Program East Campus 61554
LASALLE St. Mary's Hospital School of Practical Nursing 1015 O'Connor St. 61301	PEORIA Peoria School of Practical Nursing 509 W. High St. 61606
MALTA Kishwaukee Community College of Practical Nursing Malta 60150	QUINCY Quincy School of Practical Nursing 820 Vermont Street 62301
MATTOON Lakeland College School of Practical Nursing 1921 Richmond 61938	RIVER GROVE Triton Junior College, Practical Nursing Program 2000 N. Fifth Ave. 60171
MOLINE Black Hawk College Practical Nursing Program 1001-16th St. 61265	ROCKFORD Rockford School of Practical Nursing 201 S. Madison 61101
MT. CARMEL Wabash Valley College Practical Nursing Program 2222 College Dr. 62863	SKOKIE Niles Township H.S. School of Practical Nursing Oakton and Edens Expressway 60018
MT. VERNON Rend Lake College Practical Nursing Program 315 South 7th 62864	SPRINGFIELD Springfield School of Practical Nursing 1101 S. 15th St. 62704
OAK FOREST Oak Forest Hospital School of Practical Nursing 15900 S. Cicero 60452	STREATOR Streator Township High School Practical Nurse Program 600 N. Jefferson 61364
	WAUKEGAN College of Lake County Practical Nurse Program 312 Glen Flora 60085

ILLINOIS STATE GOVERNMENT

The state government is divided into three branches—legislative, executive, and judicial. The legislative power is vested in the General Assembly, which is composed of the State Senate and the House of Representatives (a bicameral assembly).

For representation in the General Assembly, there are 58 senatorial districts and 59 representative districts. Each senate district elects one senator; each representative district elects three representatives. Thus, the Senate has 58 members and the House 177. The senators are elected for four-year terms, and the representatives serve two-year terms. Under normal procedure, Senators in the districts having even numbers are elected in Presidential election years; those in districts with odd numbers are chosen at elections in the intervening even-numbered years. However, recent requirements for reapportionment have created changes in this pattern.

The General Assembly normally meets in the first six months of each odd-numbered year. Recently, because of annual budgeting by the Administration, special sessions have been called during the even numbered years. The General Assembly's functions are to enact, amend, or repeal laws or adopt appropriation bills, act on amendments to the United States Constitution, propose and submit amendments to the State Constitution, and to act to remove public officials.

When the House of Representatives is organized, a Speaker or presiding officer is elected for the biennium. The presiding officer of the Senate is the Lieutenant Governor. To facilitate the handling of legislation, the members of the Senate and House are assigned to designated committees to consider bills of like subject matter. These committees usually hold public hearings to discuss legislation before the measure is taken up by the entire House or Senate. There are approximately 50 committees.

EXECUTIVE BRANCH

The Constitution provides that the Executive Department shall consist of the Governor, Lieutenant Governor, Secretary of State, Auditor of Public Accounts, Treasurer, Superintendent

of Public Instruction, and Attorney General. All of these officials are elected for four-year terms. The Treasurer is the only elected state official who cannot succeed himself.

LEGISLATIVE BRANCH

Legislative Procedure

Each member of the General Assembly has the right to introduce bills or resolutions. When a bill is introduced it is read at large a first time, ordered printed, and referred to the proper committee for consideration, except that in case of an emergency, a bill may be advanced without reference to committee. If the committee recommends the bill favorably, it is sent to second reading when amendments to it can be offered for consideration by the entire membership. The bill will then be given a third and final reading when it is acted upon by the entire membership of the house that is considering it.

Action by Both Houses

To pass, the bill must receive the favorable vote of the majority of the members elected (89 in the House; 30 in the Senate). These bills are then sent to the other house where essentially the same procedure is followed.

If, because of amendments in the second house, there are two versions of the same bill, conference committees may be appointed to work out the differences. Both houses must vote favorably on the same version of the bill before it can be sent to the Governor for his consideration.

If the Governor thinks the bill should become a law, he can either sign it or file it with the Secretary of State without his signature. If the Governor decides it would be unwise for the bill to become law, he can veto it. If he vetoes the bill, he must file a statement of objections. Two-thirds of the members elected to the House can override the veto. He can also veto specific items of an appropriation bill.

Appropriation Bills

"Bills making appropriations of money out of

the treasury shall specify the objects and purposes for which the same are made, and if the Governor shall not approve any one or more of the items or sections contained in any bill, but shall approve the residue thereof, it shall become a law as to the residue in like manner as if he had signed it. The Governor shall then return the bill with any objections to the items or sections of the same not approved by him to the House in which the bill shall have originated, which House shall enter the objections at large upon its journal and proceed to reconsider so much of said bill as is not approved by the Governor. Any item or section of said bill not approved by the Governor shall be passed by two-thirds of the members elected to each of the two Houses of the General Assembly, it shall become part of said law, notwithstanding the objections of the Governor. Any bill which shall not be returned by the Governor within ten days, Sundays excepted, after it shall have been presented to him, shall become a law in like manner as if he had signed it, unless the General Assembly shall, by their adjournment, prevent its return, in which case it shall be filed with his objections in the office of the Secretary of State within ten days after such adjournment or become a law." (Article V, Section 16, Illinois Constitution)

NOTE

A Legislative Directory containing the names and addresses of all members of the 76th Illinois General Assembly and the Illinois Senators and Representatives in the Congress is available. Requests should be directed to: Illinois State Medical Society, Regional Office, 520 S. Sixth St., Springfield, 62701.

STATE OFFICERS

Governor, RICHARD B. OGILVIE, Rep., Chicago
Lieutenant Governor, PAUL M. SIMON, Dem., Troy
Secretary of State, PAUL POWELL, Dem., Vienna
Auditor of Public Accounts, MICHAEL J. HOWLETT, Dem., Chicago
State Treasurer, ADLAI E. STEVENSON, III, Dem., Chicago

Attorney General, WILLIAM J. SCOTT, Rep., Evanston
Superintendent of Public Instruction, RAY PAGE, Rep., Springfield
Clerk of the Supreme Court, JUSTIN TAFT, Rep., Rochester

DEPARTMENT OF PUBLIC AID

The Illinois Department of Public Aid administers the federally aided public assistance programs: Assistance to the Aged, Blind or Disabled; Aid to Dependent Children; and Medical Assistance. In addition, the department allocates state funds to qualified governmental units for the administration of General Assistance; and in cooperation with the United States Department of Agriculture, administers the Food Stamp program.

Administrative Staff

Harold O. Swank, Director
Gershom Hurwitz, Deputy Director
Robert L. Hyde, Chief, Division of Accounting
Garrett W. Keaster, Chief, Division of

Administrative Services

Frank P. Higgins, Chief, Division of Adult Education and Child Care

James M. Brown, Chief, Division of
Downstate Operations

Henry A. Holle, M.D., Medical Director,
Division of Medical Services

Robert G. Wessel, Chief, Medical Administration

Kenneth E. Doebelin, Chief, Division of
Methods and Data Services

Gordon G. Watters, Chief, Division of Program
Development

Wayne D. Epperson, Chief, Division of
Research and Statistics

Richard N. Hosteny, Chief, Division of
Special Investigations

William M. Fishback, Chief, Division of Special
Services

Regional Offices

Region I —Peoria Frank G. Blumb,
Regional Director

Region II —Champaign C. H. Colwell,
Regional Director

Region III—Springfield Robert A. Hamrick,
Regional Director

Region IV—Belleville Armin A. Rippelmeyer,
Regional Director

Region V Marion Lawrence E. Duff
Regional Director

Region VI—Rockford Reno L. Lenz,
Regional Director

Medical Care Advisory Committee

Murray H. Finley, Chicago

Mrs. Mary L. Ford, Chicago

Samuel A. Goldsmith, Chicago

Mrs. Jeannette Kramer, Palatine

Chauncey C. Maher, Jr., M.D., Springfield

Frank McCallister, Chicago

B. E. Montgomery, M.D., Harrisburg

Robert C. Muehrcke, M.D., Oak Park

Harold W. Pratt, R.Ph., Chicago

State Medical Advisory Committee

Louis Arp, Jr., M.D., Moline

Charles E. Baldree, M.D., Belleville

James R. Cooper, M.D., Quincy

Earl E. Fredrick, Jr., M.D., Chicago

Frank J. Jirka Jr., M.D., Berwyn

Paul F. LaFata, M.D., Springfield

George F. Lull, M.D., Chicago

Rex O. McMorris, M.D., Peoria

George T. Mitchell, M.D., Marshall

Robert C. Muehrcke, M.D., Oak Park

Jacob E. Reisch, M.D., Springfield

Alphonse L. Robinson, M.D., Mounds

Philip G. Thomsen, M.D., Dolton

Fred A. Tworoger, M.D., Chicago

State Drug Advisory Committee

W. Edwin Brown, R.Ph., Quincy

Carl V. Daschka, R.Ph., Chester

H. M. F. Doden, Sr., R.Ph., Rock Island

Justin Eisele, R.Ph., East St. Louis

Louis Gdalan, R.Ph., Chicago

John T. Gulick, R.Ph., Danville

John F. Koller, R.Ph., Berwyn

Roy B. Maher, R.Ph., Springfield

Harold W. Pratt, R.Ph., Chicago

Theodore R. Sherrod, M.D., Ph.D., Chicago

Harold J. Shinnick, R.Ph., Chicago

Charles P. Skaggs, R.Ph., Harrisburg

State Dental Advisory Committee

John C. Barrett, D.D.S., Freeport

John J. Byrne, D.D.S., Chicago

Chauncey Cross, D.D.S., Springfield

Vernon J. Haas, D.D.S., Bloomington

Lewis K. Holzman, D.D.S., Chicago

Robert B. Jans, D.D.S., Evanston

D. J. McCullough, D.D.S., Wayne City

H. B. Riley, D.D.S., Newton

William J. Rogers, D.D.S., Chicago

Carl L. Sebelius, D.D.S., Springfield

Harold H. Sitron, D.D.S., Chicago

State Advisory Committee on Group Care Facilities

Don T. Barry, Raymond

Taylor O. Braswell, Belleville

Bert Cohn, Okawville

Mrs. Rachel Dodson, Herrin

William K. Ford, M.D., Rockford

Markham D. Hay, Rockford

Mrs. Bernice Hover, Chicago

Elmer Johnson, Joliet

Mrs. Laverta Johnson, Chicago

Mrs. Jeannette Kramer, Palatine

Robert E. Lanier, Springfield

Roger F. Sondag, M.D., M.P.H., Springfield

**Legislative Advisory Committee on
Public Assistance**

The Honorable Merle K. Anderson, Durand
The Honorable Meade Baltz, Joliet
The Honorable Charles M. Campbell, Danville
The Honorable John W. Carroll, Park Ridge
The Honorable Corneal A. Davis, Chicago
The Honorable Daniel Dougherty, Chicago
The Honorable Egbert B. Groen, Pekin
The Honorable James G. Krause, East St. Louis
The Honorable Robert E. Mann, Chicago
The Honorable Don A. Moore, Midlothian
The Honorable Esther Saperstein, Chicago
The Honorable Fred J. Smith, Chicago

Board of Public Aid Commissioners

Charles A. Davis, Chicago
Robert G. Gibson, Chicago
Robert H. MacRae, Chicago
Chauncey C. Maher, Jr., M.D., Springfield
Mrs. Woods McCausland, Winnetka
Thomas A. Nieman, Rockford
Robert W. Weissmiller, Mount Carroll

Ex-Officio members

Albert J. Glass, Acting Director,
Department of Mental Health, Springfield
Edward F. Lis, M.D., Director,
Division of Services for Crippled Children
University of Illinois College of Medicine,
Chicago
Alfred Slicer, Director,
Division of Vocational Rehabilitation, Springfield
Edward T. Weaver, Director,
Department of Children and Family Services,
Springfield
Franklin D. Yoder, M.D., M.P.H., Director,
Department of Public Health, Springfield

Department of Public Aid Representatives

Henry A. Holle, M.D., Medical Director,
Division of Medical Services
Robert G. Wessel, Chief,
Medical Administration
Division of Medical Services

**DIVISION OF VOCATIONAL
REHABILITATION**

The Board of Vocational Education and Rehabilitation is a statutory body, established to administer, through two operating divisions, the state program of vocational and technical edu-

cation pursuant to the Federal Vocational Education Act as amended, and the state program of vocational rehabilitation pursuant to the Federal Vocational Rehabilitation Act as amended.

Board of Vocational Education and Rehabilitation

Ex Officio:

Director of Agriculture
Director of Labor
Director of Mental Health
Director of Public Health
Director of Registration and Education
Director of Children and Family Services
Superintendent of Public Instruction

Appointive Members (appointed by Governor):

Helen Schmid, Glen Ellyn
James D. Broman, Chicago
Robert Friedlander, Chicago
William Gellman, Ph.D., Chicago
Edward T. Scholl, Chicago

Executive Officers:

For vocational education: Ray Page,
Superintendent of Public Instruction
For vocational rehabilitation: Alfred Slicer,
Director, Division of Vocational Rehabilitation

Division of Vocational Rehabilitation

Alfred Slicer, Director
623 East Adams, Springfield 62706

Division of Vocational and Technical Education

Sherwood Dees, Acting Director
405 Centennial Building, Springfield 62706

**DEPARTMENT OF CHILDREN AND
FAMILY SERVICES**

Director's Office:

Room 404, New State Office Bldg.,
Room 1713, 160 N. LaSalle St.,

Springfield
Chicago

Edward T. Weaver, Director

Roman L. Haremski, Deputy Director
 William J. Lauf, Deputy Director for Management Services
 J. Keller Mack, M.D., Medical and Public Health Officer
 Philip D. Wynn, Technical Advisor
 Richard S. Laymon, Administrative Asst. to the Director and Guardianship Administrator
 528 So. Fifth St., Springfield
 Office of Community Relations:
 404 State Office Bldg., Springfield
 Donald H. Schlosser, Administrator
 Office of Planning and Community Development:
 Rm. GL4, 525 W. Jefferson, Springfield
 William H. Ireland, Director of Planning
 Thomas Villiger, Administrator of Community Development

Division of Child Welfare:

528 S. Fifth St., Springfield
 Richard J. Bond, Division Director
 Herschel L. Allen, Chief of Program Services
 Merle E. Springer, Chief of Metropolitan Operations
 Ralph L. Hanebutt, Chief of Downstate Operations

Regional and District Offices—

AURORA REGION (Leland Wright, Reg. Dir.),
 361 Old Indian Trail

Aurora District, 361 Old Indian Trail
 Joliet District, Rm. 309, 57 W. Jefferson
 Waukegan District, 4 S. Genesee St.

CHAMPAIGN REGION (Thomas L. Tucker, Reg. Dir.), 2125 So. First St.

Champaign District, 2125 S. First St.
 Bloomington District, 309 W. Market St.
 Decatur District, 125 N. Franklin St.
 Kankakee District, Rm. 300, 70 Meadowview Center

Mattoon District, 1000 Broadway

CHICAGO REGION (Ralph Baur, Reg. Dir.),
 1026 S. Damen Avenue

East District, 2030 S. Michigan Ave.
 Herrick House Children's Center, W. Bartlett Rd., Bartlett
 Lawndale Day Care Center, 2929 W. 19th, Chicago

EAST ST. LOUIS REGION (Jack M. Donahue, Reg. Dir.), 310 N. Tenth St.

East St. Louis District, 917 Illinois Avenue
 Olney District, 1108 S. West St.
 Salem District, 205 E. Locust St.

MURPHYSBORO REGION (E. Paul Nelson, Reg. Dir.), 9 South 12th Street

Murphysboro District, 21 N. 11th St.
 Cairo Office, 529 Cross St.
 Harrisburg District, 10 S. Vine St.
 Metropolis Office, City National Bank Bldg., P.O. Box 757

Southern Illinois Children's Service Center,
 (James W. DeLeonardis, Acting Admin.),
 Hurst

PEORIA REGION (Francis R. Paule, Reg. Dir.),
 5415 N. University Ave.

Peoria District, 5415 N. University Ave.

Galesburg District, 121 S. Prairie

Moline District, 1805 Seventh St.

Princeton Office, 22 E. Marion

ROCKFORD REGION (Margaret M. Kennedy, Reg. Dir.), 4302 N. Main St., P.O. Box 915
 Rockford District, 4302 N. Main St., P.O. Box 915

Ottawa District, 412 W. Madison St.

Rock Falls District, 203½ First Ave.

SPRINGFIELD REGION (William W. Sanders, Reg. Dir.), Rm. 122, 4500 S. Sixth St. Rd.
 Springfield District, Rm. 122, 4500 S. Sixth St. Rd.

Carlinville District, 494½ W. Side Square

Jacksonville District, 602 Westgate Ave.

Quincy District, 410 N. Ninth St.

Division of Educational and Rehabilitation Services:

404 State Office Bldg., Springfield

Lee A. Iverson, Division Director

Institutions—

Illinois Braille and Sight Saving School

(Jack Hartong, Supt.), Jacksonville

Illinois School for the Deaf

(Kenneth Mangan, Supt.), Jacksonville

Illinois Children's Hospital-School

(Paul Kavanaugh, Supt.), 1950 W. Roosevelt Rd., Chicago

Illinois Soldiers' and Sailors' Children's School
 (Andrew Spelios, Supt.), Normal

Charles Adams, Chief of Rehabilitation Services

404 State Office Bldg., Springfield

Institutions—

Illinois Soldiers' and Sailors' Home

(Richard Northern, Supt.), Quincy

Illinois Visually Handicapped Institute

(Thomas Murphy, Supt.), 1151 S. Wood St., Chicago

Visually Handicapped Services—

Community Services for the Visually Handicapped

(I. N. Miller, Supt.), Rm. 1700, 160 N. LaSalle St., Chicago

(Field offices located in regional offices in counties other than Cook County—see listings under Division of Child Welfare)

Raymond M. Dickinson, Coordinator of Visually Handicapped Services

404 State Office Bldg., Springfield

Division of Financial Management:

404 State Office Bldg., Springfield

Matthew J. Finnell, Division Chief

Division of Systems and Data Processing:

630 E. Adams St., Springfield

August G. Egger, Jr., Division Chief

Division of Personnel Administration:

404 State Office Bldg., Springfield

Thomas A. Nickell, Chief Personnel Officer

DEPARTMENT OF REGISTRATION AND EDUCATION

William H. Robinson, *Director*
Allen M. Andreasen, *Deputy Director*
Edward Price, *Coordinator*,

Division of Professional Supervision

The department is primarily concerned with the registration, licensing and enforcement of 32 laws governing the different professions, trades and occupations, including the Medical Practice Act. Enforcement of the Medical Practice Act is in the Division of Professional Supervision headed by a coordinator. Registration and licensing is under the jurisdiction of the Division of Registration.

The Medical Examining Committee appointed by the director of the department operates within the framework of the act and is charged with the responsibility of giving examinations for licensure, hearing complaints for revocation and suspension of licenses and promulgating rules and regulations for the administration of the act.

Medical Examining Committee

Eugene Hoffman, D.C.
William Johnson, M.D.
William G. McCarthy, M.D.
Dale E. Richardson, D.O.
Kenneth H. Schnepf, M.D.
Warren D. Tuttle, M.D.

Medical Practice Act

LICENSING AND ENFORCEMENT PROCEDURES

Illinois statutes provide for licensing of physicians to practice medicine "(1) in all of its branches, and (2) licensing of those persons to treat human ailments without the use of drugs or medicine and without operative surgery."

The Medical Practice Act states, "no person shall practice medicine or any of its branches or midwifery, or any system or method of treating human ailments without the use of drugs or medicines, or without operative surgery, without a valid existing license so to do." Applicant for license must pass an examination of his qualifications which must be satisfactory to the Department of Registration and Education.

REQUIRED EDUCATION

Minimum standards of professional education: 2 years' course of instruction in a college of liberal arts or its equivalent, or in such medical college in a course of instruction in the treatment of human ailments which course shall have been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months and in addition, a course of clinical training of not less than 12 months in a hospital. The college of liberal arts, medical school, and hospital must be reputable and in good standing in the judgment of the Department of Registration and Education.

All examinations provided by the Medical Practice Act shall be conducted by the Department of R&E. Examinations of applicants who seek to practice medicine in all of its branches which shall embrace the subjects of which knowledge is generally required of candidates for the degree of Doctor of Medicine by reputable medical colleges in the U.S., and shall be such in the judgment of the Department of R&E that will determine the qualifications of applicants to practice medicine in all of its branches.

Every license issued under the Act expires on July 1 of each even-numbered year. Every licensee under the Act may, biennially during the month of June of each even-numbered year, renew his license upon paying to the Department a renewal fee of \$10.

REVOCATION AND SUSPENSION OF LICENSE OR CERTIFICATE

The department may revoke or suspend the license, certificate, or state hospital permit of any person licensed under the act upon any of the following grounds:

- "1. Conviction of procuring or attempting or aiding to procure such an abortion as was made unlawful at the time under the Criminal Code of this State;
2. Conviction in this or another state of any crime which is a felony under the laws of this state or conviction of a felony in a federal court.
3. Gross malpractice resulting in permanent injury or death of a patient;
4. Engaging in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud, or harm the public;
5. Obtaining a fee, either directly or indirectly, either in money or in the form of anything else of value or in the form of financial profit as personal compensation, or as compensation, charge, profit or gain for an employer or for any other person or persons, on the fraudulent representation that a manifestly incurable condition of sickness, disease or injury of any person can be permanently cured;
6. Habitual intemperance in the use of ardent spirits, narcotics, or stimulants to such an extent as to incapacitate for performance of professional duties;
7. Holding one's self out to treat human ailments under any name other than his own, or the personation of any other physician;
8. Employment of fraud, deception or any unlawful means in applying for or securing a license, certificate, or state hospital permit to practice the treatment of human ailments in any manner, to practice midwifery, or in passing an examination therefor, or willful and fraudulent violation of the rules

and regulations of the department governing examinations;

9. Holding one's self out to treat human ailments by making false statements, or by specifically designating any disease, or group of diseases and making false claims of one's skill or the efficacy or value of one's medicine, treatment or remedy therefor;
10. Professional connection or association with, or lending one's name to, another for the illegal practice by another of the treatment of human ailments as a business, or professional connection or association with any person, firm, or corporation holding himself, themselves, or itself out in any manner contrary to this Act;
11. Revocation or suspension of a medical license in a sister state.
12. A violation of any provision of this Act or of the rules and regulations formulated for the administration of this Act;
13. Except as otherwise provided in Section 16.01, advertising or soliciting by himself or through another, by means of hand bills, posters, circulars, stereopticon slides, motion pictures, radio, newspapers or in any other manner for professional business."

Section 16.01. Any person licensed under this Act may list his name, title, office hours, address, telephone number and any specialty in professional and telephone directories; may announce by way of a professional card not larger than 3½ inches by 2 inches, only his name, title, degree, office location, office hours, phone number, residence address and phone number and any specialty; may list his name, title, address and telephone number and any specialty in public print limited to the number of lines necessary to state that information; may announce his change of place of business; absence from, or return to business in the same manner; or may issue appointment cards to his patients, when information thereon is limited to the time and place of appointment and that information permitted on the professional card. Listings in public print, in professional and telephone directories, or announcements of change of place of business, absence from, or return to business, may not be made in bold faced type.

Rules and Regulations Adopted for the Administration of the Illinois Medical Practice Act, Effective March 18, 1955

RULE I—ACCREDITED COLLEGES OF MEDICINE AND SURGERY

Medical colleges having rules and curricula commensurate with and equivalent to the rules and curricula of the College of Medicine of the University of Illinois, will be considered for accreditation by the Department of Registration and Education.

RULE II—ACCREDITED COLLEGES TEACHING SYSTEMS OF TREATING HUMAN AILMENTS WITHOUT THE USE OF DRUGS OR MEDICINE AND WITHOUT OPERATIVE SURGERY.

A professional college or institution teaching a system of treating human ailments without the use of drugs or medicine and without operative surgery shall be deemed reputable and in good standing in the judgment of the Department upon submission of proof of the following requirements:

(a) That a Dean or other Executive Officer, employed on a full-time basis supervises the students and curriculum.

(b) That the faculty is comprised of graduates in their specialty from recognized professional colleges or institutions.

(c) That the faculty is organized and each department has a director, professors, associate professors and assistant professors, each responsible to his superior for his instruction in the particular subject he teaches.

(d) That, annually, a catalogue or brochure is published setting forth the requisites for admission to the college, tuition rates, courses offered, dates of sessions, schedule of classes, requirements for graduation, a roster of the undergraduate students and a roster of the last graduating class. The catalogue or brochure shall contain a list of the departments of the school, the titles of the personnel and a brief summary of each person's qualifications. The curriculum shall include, but not be limited to, four academic years' instruction in the following subjects:

(1) Anatomy

(a) Embryology

(b) Histology

(c) Neuro-anatomy

(2) Physiology and Chemistry

(3) Pathology and Bacteriology

(4) Diagnosis

(a) Physical

(b) Differential

(c) Laboratory

(e) That suitable buildings provided with laboratories equipped for instruction in anatomy, chemistry, physiology, pathology, bacteriology and other areas of learning necessary to the due course of study prescribed by these rules; and that a laboratory equipped with supplies, models, manikins, charts, stereopticon, roentgen-ray and other special apparatus used in teaching the system to treat human ailments without the use of medicine and operative surgery, be provided.

(f) That a working library, easily accessible to students, is maintained from at least 9 a.m. to 5 p.m., with a librarian in constant attendance. The library shall contain a standard medical dictionary, the modern text and reference books, and the files of leading periodicals dealing with the particular system of treating human ailments without the use of medicine and operative surgery.

(g) That the college or institution requires all

students to furnish, before matriculation, satisfactory proof of the preliminary education required by the Medical Practice Act.

(h) That full and complete records are kept showing the credentials for admission, attendance, grades and financial accounts of each student.

(i) That admission of transfer students will be limited to honorably dismissed students from another approved college or institution teaching the same system. The transcript of record obtained directly from the transferring school shall be kept on file. It shall be the duty of a college or institution to furnish such a transcript for the benefit of each student subject to honorable dismissal. No credit shall be given a transferred student for final or "senior year" work or for any courses taken by correspondence.

(j) That students shall start class attendance within one week of the start of each session. That credit for completion of a course will not be granted a student who failed to attend 80 per cent of the complete session of the course.

RULE III—HOSPITALS APPROVED FOR INTERNSHIP.

1. A hospital shall, in the judgment of the Department be deemed reputable and in good standing for training interns and intern services when it meets the following standards:

(a) General hospital of 150 beds' capacity, with an average of at least 60 patients daily, with rotating service.

(b) Shall contain at least the departments of internal medicine, surgery, obstetrics and pediatrics; and an organized departmentalized staff, holding meetings monthly for case reviews and study.

(c) Laboratory employing a full-time qualified technician and at least a part-time qualified pathologist, visiting the laboratory at least two days per week.

(d) Radiological department employing a qualified X-ray technician and at least a part-time qualified roentgenologist, visiting the department at least two days per week.

(e) Maintenance of an up-to-date medical library located in a suitable study room available to interns.

(f) Such hospital shall provide and furnish the Department with the names of staff members of the various departments of the hospital.

(g) The hospital, upon the completion of a course of training therein of not less than twelve months, shall issue its certificate therefor to any such intern or at the request of the Department, such certificate shall include therein, by date, the commencement and the conclusion thereof.

2. An approved internship shall consist of twelve months rotating service in medicine, surgery, obstetrics and pediatrics, with an election in medical specialties.

In the event an applicant has received training

in excess of the twelve months' period specified by the Medical Practice Act, and if this be in an institution approved by the Department as adequate for specialty training; and if the applicant has received certification by a recognized Medical Specialty Board, and has had two or more years' specialty practice or Military Service; such training and practice may be accepted as the equivalent of a rotating internship.

Any applicant who shall have completed twelve months of clinical training in a hospital, as required by Section 5-1(b) of the Medical Practice Act, and who has been accepted for further training in a specialty or general practice residency program by a hospital or institution approved by the Department for that purpose, shall be deemed to have complied with the requirements of this rule and of the Medical Practice Act in this regard.

RULE IV—APPLICATION FOR EXAMINATION

An applicant for examination for licensure to practice medicine in all of its branches, or any system of treating human ailments without the use of drugs or medicine and without operative surgery, must make application on forms furnished by the Department at least fifteen days prior to the examination and present, in addition:

(a) Recommendations from two (2) physicians duly licensed to practice in some state in the United States.

(b) A recent photograph, passport size, signed by applicant and the two persons licensed to practice the system of treatment of human ailments for which the applicant is seeking a license. A duplicate photograph must be presented with the card of admission at the examination.

(c) The original diploma of graduation from the professional college in which the applicant completed his course of training, or, in lieu of presenting the diploma with the application, the applicant may present it at the examination.

(d) A certified copy of secondary school and professional school studies to be mailed direct to the Department by the schools attended or by the professional schools where the applicant completed the required course of study.

(e) Proof of completion of a rotating internship of twelve months in an approved hospital for applicants seeking admission to examination for license to practice medicine in all of its branches; and, in the case of graduates of medical colleges in countries other than the United States and Canada, who apply for examination after January 1, 1953, proof of rotating internships of one year in approved hospitals in the United States.

A candidate under Section 5, paragraph 1b or Section 13, may apply for the examination or clinical test and take the examination given immediately prior to completion of his intern-

ship provided he furnishes a statement from the hospital authorities stating his internship has been satisfactory to date. The results of the examination will be withheld and no license will be issued until the Department receives proof of satisfactory completion of the required internship in an approved hospital training program.

(f) Applicants who completed their medical courses in the extramural colleges of Ireland and Scotland shall not be eligible for admission to examinations for licensure under the Illinois Medical Practice Act.

(g) Graduates of European colleges or universities after January 1, 1943, with the exception of certain approved colleges in the British Isles, Denmark, Holland, Norway, Sweden and Switzerland, be not accepted for admission to examinations for licensure under the Illinois Medical Practice Act.

Graduates of such European medical colleges after January 1, 1943 may be considered for admission to Illinois examinations provided they present diplomas of graduation from approved medical colleges in the United States after attendance in such colleges for at least one year; and in addition, have served rotating interships of one year in approved hospitals in the United States.

(h) An applicant who presented a diploma of graduation from an approved school will not be accepted, if he was accorded advanced standing in such school based upon his prior education in an unapproved school.

RULE V—EXAMINATIONS

1. Examinations for licensure to practice medicine in all of its branches shall be conducted in the English language and shall be in the following theoretical and practical areas of medicine:

THEORETICAL

Chemistry
Physiology
Anatomy
Pharmacology
Pathology
Bacteriology
Medicine
Public Health & Preventive Medicine
Obstetrics & Gynecology
Surgery
Pediatrics
Psychiatry

CLINICAL

General Practice of Medicine

2. Examinations for licensure to practice the treatment of human ailments without the use of drugs or medicine and without operative surgery shall be conducted in the English language and shall be in the following theoretical and practical subjects:

THEORETICAL

Chemistry & Physiology
Anatomy & Histology

Pathology & Bacteriology

Diagnosis

Hygiene & Medical Jurisprudence

Eye, Ear, Nose, & Throat

Dermatology, Pediatrics & Neurology

System of Practice

Obstetrics (of graduates of approved osteopathic colleges)

PRACTICAL

System of Practice

3. To be successful, applicants must receive general averages of 75% with no grade below 60 in the written examination, and a general average of 75% in the clinical or practical test.

Applicants applying for registration under Sections 12 and 12a of the Medical Practice Act shall be required to make general averages of 75% in the three subjects required for license to practice medicine and surgery in Illinois.

4. In case of failure in the first and second examinations applicants will be allowed credit on the following examination for all grades of 75 or more; but in case of failure in the third examination they must retake all written subjects at each subsequent examination. It is not required that the clinical or practical part of the examination be repeated after a passing grade of 75 has been received in that part of the examination.

5. Applicants who take the regular examination conducted by the Department for licenses as Physicians and Surgeons shall be excused from taking the clinical test.

6. An applicant for registration as Physician and Surgeon who has been unsuccessful in five examinations will be deemed to be eligible for further examination upon receipt of proof that he has completed one year of residency training in an approved hospital training program in the United States received subsequent to the applicant's fifth failure.

7. An applicant who has been unsuccessful in five examinations for registration as a drugless practitioner will be eligible for reexamination upon receipt of proof that he has completed a course of study of 960 hours in a school which is accredited under the Medical Practice Act. This course must be received subsequent to the applicant's fifth failure.

8. An applicant who furnished proof of a course of study of 240 hours in a school of chiropractic recognized by the Department in order to be eligible for further examination under Section 9a of the Medical Practice Act will be considered as a new applicant and his grades of 75 per cent or more will be carried over to the second and third examinations.

RULE VI—RECIPROCITY

1. Each applicant for registration through reciprocity, either for the practice of medicine in all

of its branches or for the treatment of human ailments without the use of drugs or medicine and without operative surgery, filed on forms provided by the Department, will be considered on its individual merits, provided the state or territory of original licensure grants a like privilege to persons licensed in Illinois.

2. If the application is not endorsed by officers of a state or county society it must be endorsed by two (2) physicians duly licensed to practice in some state in the United States.

3. Applicants for licensure through reciprocity or upon the basis of having passed the National Board Examination prior to January 1, 1964, must pass the clinical test conducted by this Department. Applicants upon the basis of the National Board Examination who completed Part III after January 1, 1964, are required to report for an interview with the Medical Examining Committee. The clinical test shall be such in the judgment of the Committee as will determine the qualifications of the applicant to practice medicine in all of its branches, taking into consideration the quality of medical education and clinical training or practical experience which the applicant has had, special honors or awards, publications in recognized and reputable journals, authorship of textbooks in medicine, and any other circumstance or attribute that the Committee accepts as evidence of an outstanding and proven ability in any branch of the field of medicine.

4. Graduates of Chiropractic colleges whose applications for registration in Illinois by reciprocity are approved, shall be required to pass a written examination in theory in addition to a practical test before the chiropractic examiner.

RULE VII—LICENSURE

1. An examinee who successfully completes his medical examination must secure his certificate of licensure within one year from the date of his examination.

2. The Department will not issue a duplicate certificate of registration to practice medicine in all of its branches, or to treat human ailments without the use of drugs or medicine and without operative surgery, unless proof satisfactory to the Department and the Committee is presented that the original certificate was destroyed; or in case of change of name when the original certificate is returned for cancellation, together with satisfactory legal proof of such change of name.

3. A license to practice medicine in Illinois shall be a requisite for a residency in an Illinois hospital.

RULE VIII—TEMPORARY CERTIFICATES OF REGISTRATION

1. Any person not licensed to practice medicine in all of its branches in the State of Illinois who wishes to pursue a program of graduate or specialty or residency training in this State, must be the holder of a Temporary Certificate of Registration issued by the Department under the

provisions of Section 11a of the Medical Practice Act of Illinois and in accordance with the provisions of the within Rules.

2. Application for a Temporary Certificate must be made on blank forms prepared and furnished by the Department. It must be submitted to the Department together with evidence satisfactory to the Department that applicant meets the requirements of Section 11a of the Illinois Medical Practice Act and that if his application is approved he will be accepted or appointed for the residency training in the hospital designated in such application.

3. A Temporary Certificate of Registration will be issued on behalf of an otherwise qualified applicant only for residency or specialty training in a hospital situated in this State which is approved by the Department for the purpose of such training. An approved hospital is one which in the judgment of the Department is qualified to offer such training, and which shall comply with the within Rules.

4. Written notice of the Department's final action on every application for a Temporary Certificate of Registration shall be given to the applicant and the hospital designated therein; when such application is approved the Temporary Certificate of Registration shall be delivered or mailed to the hospital designated therein and shall be kept in the care and custody of such hospital. The applicant shall not commence such specialty or residency training before he or the hospital receives written notification of approval of his application.

5. A Temporary Certificate of Registration shall not be valid for longer than one year after issuance thereof and may be renewed from time to time, in the discretion of the Department, for a period of not more than one year each time. Application for renewal must be made on forms prepared and furnished by the Department and the Temporary Certificate of Registration sought to be renewed must be submitted therewith to the Department.

6. When any person in whose behalf a Temporary Certificate of Registration has been issued shall be discharged or shall terminate his specialty or residency training in the hospital designated therein, such hospital shall immediately deliver or mail by registered mail to the Department his Temporary Certificate of Registration and written notice of the reason for return of same.

7. A Temporary Certificate of Registration is not transferable without prior notice to and approval by the Department. If the holder of a Temporary Certificate of Registration wishes to change to another training program in the approved hospital designated therein, or he wishes to enter a training program in another approved hospital, he must make application on Forms furnished by the Department. His current Temporary Certificate of Registration must accompany such application and he cannot thereafter continue

in the training program designated on such current Certificate, and he may not commence such other training program until a Temporary Certificate of Registration has been issued therefor.

8. Not more than one Temporary Certificate of Registration shall be issued to any person for the same period of time. A person on whose behalf a Temporary Certificate of Registration has been issued is limited in the practice of medicine to the performing of such acts as may be prescribed by and incidental to his program of residency training in the hospital designated in his Temporary Certificate of Registration, and he cannot otherwise engage in the practice of medicine in the State of Illinois.

9. Whenever, under the within Rules, a hospital is required to deliver or return a Temporary Certificate of Registration to the Department, in case, because of the loss or destruction of such Certificate, or for any other reason, such hospital shall be unable immediately so to deliver or mail such Certificate, such hospital shall immediately mail or deliver to the Department a written explanation in detail of such inability.

10. The holder of a Temporary Certificate of Registration is not barred thereby from becoming eligible for admission to the Department examination for a license to practice medicine in Illinois if he otherwise meets the requirements for admission to such examination and if such person should fail to pass such examination such failure shall not bar him from completing his training program.

RULE IX—LIMITED LICENSES TO PRACTICE IN STATE HOSPITALS

1. Each application made on forms provided by the Department will be considered on its own merits.

2. The State Hospital at which the applicant will practice under the supervision of a medical officer, shall signify to the Department that the hospital will appoint the applicant in the event he receives a Limited License.

3. Any applicant for a Limited License who has failed in more than three examinations for licensure under the Illinois Medical Practice Act shall not be eligible for a Limited License.

ECFMG REQUIREMENTS

The Education Council for Foreign Medical Graduates (ECFMG) commenced operations in October, 1957. Sponsors of this agency are the American Hospital Association, American Medical Association, Association of American Medical Colleges, and Federation of State Medical Boards of the United States. ECFMG gives two examinations a year to foreign medical graduates. The examinations test the graduate's general knowledge of medicine and command of English.

Persons successfully passing this examination are granted an ECFMG certificate. This certificate

in the State of Illinois is **not a substitute** for nor is it the equivalent of licensure to practice medicine. It simply indicates that the holder's command of English has been tested and found adequate for assuming an internship in an American hospital. The holder of such a certificate may not practice medicine in any degree in a hospital in Illinois unless he is within one of the categories outlined above.

Offenses Listed

An unlicensed person who commits any of the following acts regardless of whether the same be committed within or without a hospital is guilty of practicing medicine without a license—a criminal offense:

1. Hold himself out to the public as being engaged in the diagnosis or treatment of ailments of human beings.
2. Suggest, recommend or prescribe any form of treatment for the palliation, relief or cure of any physical or mental ailment of a person with the intention of receiving therefor, either directly or indirectly, any fee, gift, or compensation whatsoever.
3. Diagnosticate or attempt to diagnosticate any ailment or supposed ailment of another.
4. Operate upon, profess to heal, prescribe for, or otherwise treat any ailment, or supposed ailment of another.
5. Maintain an office for examination or treatment of persons afflicted, or alleged or supposed to be afflicted, by any ailment.
6. Attach the title Doctor, Physician, Surgeon, M.D., or any other word or abbreviation to his name, indicative that he is engaged in the treatment of human ailments as a business.

(Section 24 *Medical Practice Act*. [Chp. 91, Sec. 16i, 1967 Rev. Stat.])

Manifestly, the enforcement of the Medical Practice Act with respect to the elimination of unlicensed persons practicing medicine in a hospital is dependent upon co-operation by responsible persons within the hospital. It should be noted that lack of co-operation or failure to meet responsibilities can in a proper case be translated into criminal liability and disciplinary action resulting in revocation or suspension of a license to practice medicine as follows:

1. The unlicensed person practicing medicine is committing a criminal offense.
2. A hospital administrator who assigns an unlicensed person to duties which involve his practicing medicine may subject himself to the criminal offense of aiding and abetting such unlicensed person to illegally practice medicine, and the same may be true of a hospital chief of staff or department head if in the nature of his duties he is directly responsible for assigning such duties to the unlicensed person.

3. A licensed doctor may have his license suspended or revoked if he has professional connection or association with another who is illegally practicing medicine. A chief of staff who knowingly allows such person to illegally practice medicine, or in a proper case, any member of the medical staff of a hospital may subject himself to disciplinary action against his license.
4. A licensed doctor may have his license suspended or revoked for unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public.

A member of the medical staff of a hospital may place himself within such conduct if he neglects, fails or refuses to fulfill his responsibilities while on emergency room call.

Other Examining Boards

Examining boards operating under the jurisdiction of the Department of Registration and Education are:

Medical Examining Committee

Eugene Hoffman, D.C.
William Johnson, M.D.
William McCarthy, M.D.
Dale E. Richardson, D.O.
Kenneth H. Schnepf, M.D.
Warren D. Tuttle, M.D.

Chiropody-Podiatry Examining Committee

Dr. Charles H. Delano
Alva J. Harler, D.S.C.
Dr. Theodore S. Hollingsworth

Dental Examining Committee

Dr. Eugene E. Ausbrook
Dr. Hugh D. Burke

Dr. Ralph H. Council
Dr. Herbert C. Gustavson
Dr. Peyton Sidney Newwirth
Dr. William Osmanski
Dr. Adrian L. Swanson

Committee of Nurse Examiners

Sister Mary Francis Cooke
Mrs. Donna Hessler
Mrs. Ina Ingwersen
Mrs. Mary Lennan
Mrs. Lillian G. Oertel
Mrs. Harriet S. Olson

Optometry Examining Committee

Dr. Jose E. Aposte
Dr. Stanley F. Maer
Dr. Irving C. Morgan
Dr. Geve Ossello
Dr. Floyd Woods

Illinois State Board of Pharmacy

John Barlow
Joseph Davidson
Louis Gdalan
Fred L. Janes
Daniel Nona
Harold W. Pratt
Philip Sacks

Physical Therapy Examining Committee

Mr. Robert Babbse Jr.
Mr. James Mason Gray
Miss Vilma Evans

Psychologist Examining Committee

Dr. Philip Ash
Dr. Roy Brener
Dr. Wendell Dysinger
Dr. Leroy A. Wauk

DEPARTMENT OF MENTAL HEALTH

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John F. Briggs, Deputy Director
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Herman E. Heinecke, Administrative Assistant
Margaret B. Holloway, Administrative Assistant
James Walsh, Administrative Assistant
Robert E. Lanier, Special Assistant

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Peter K. Levison, Ph.D., Manager, Research and Development
Louis Aarons, Ph.D., Research and Development Executive

Management Group

Division of Manpower Development

Steve Davis, Chief, Employee Communications

Division of Legislative Liaison

H. Dickson Buckley, Manager

Division of Financial Management

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C. Balthazor, Chief, Budgetary Services

Frank Campbell, Chief, Grants
George Skadden, Chief, Audit
Ron Allen, Acting Chief, Analysis and Evaluation

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John Meyer, Chief Personnel Officer

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Drug Abuse Programs

Jerome Jaffe, M.D., Director

Alcoholism Programs

Uwe Gunnensen, Director

Physical Education Activity and Recreation

L. Hopkins

Communications

R. O. Bacon, Specialist

Reimbursement Services

M. F. Burkhardt, Chief

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H. Douglas Singer

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CHICAGO AREA ZONE: Patrick Staunton, M.D., Ad-
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ELGIN STATE HOSPITAL: Daniel A. Manelli, M.D.,
Superintendent, Elgin 60120

MANTENO STATE HOSPITAL: H. C. Piepenbrink,
Superintendent, Manteno 60950

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GALESBURG STATE RESEARCH HOSPITAL:
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KANKAKEE STATE HOSPITAL: Gabriel Misevic, M.D.,
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CARBONDALE: Robert C. Steck, M.D., Administrator,
Anna 62906

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ILLINOIS SECURITY HOSPITAL: Vernon J. Uffelman,
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Lester H. Rudy, M.D., Administrator, Medical Center
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Lawrence Bussard, Assistant Administrator

Charles Jubenville, Ed.D., Assistant Administrator

Richard Blanton, Ph.D., Assistant Administrator

Christian Simonson, Day Care Consultant

James Howell, Individual Care Grants and Waiting List

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ILLINOIS REGIONAL MEDICAL PROGRAM REGIONAL ADVISORY COMMITTEE

The Regional Medical Program for Heart Disease, Cancer, Stroke and Related Diseases was established by Congress in 1965 as Public Law 89-239. The Illinois Regional Medical Program, which began in 1967, is now incorporated by the seven Illinois medical schools, the Chicago College of Osteopathic Medicine, and their major teaching hospitals. The Program seeks to improve patient care by closing the gap between sci-

ence and service. It encourages the establishment of voluntary cooperative arrangements among various health-related organizations, agencies, and institutions in the region. An Advisory Group representative of the region gives overall guidance to the Program as required by law. It must approve all project applications submitted for funding.

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E. L. Sederlin, M.D., Health Officer, 306 West Main Street, Carbondale 62901. Counties of Hamilton and Perry and consultation to full-time health departments of Egyptian (Gallatin-Saline-White), Franklin-Williamson, Jackson, Quadri-County (Hardin-Johnson-Massac-Pope), Randolph, Tri-County (Alexander-Pulaski-Union).

Region II:

E. E. Diddams, M.S.P.H., Acting Health Officer, 9500 Collinsville Road, Unit E., Collinsville, 62234. Counties of Clinton, Crawford, Edwards, Fayette, Jasper, Jefferson, Madison, Marion, Richland, St. Clair, Wabash, Washington, and Wayne and consultation to full-time health departments: Counties—Bond, Clay, Lawrence and Monroe; Urban—East Side Health District (Canteen-Centreville-East St. Louis-Stites Townships).

Region III:

Evelyn M. Cunningham, R.N., Acting Health Officer, Room 173, State Regional Office Building, 4500 South Sixth Street Road, Springfield 62706. Counties of Brown, Cass, Hancock, Logan, Macoupin, Mason, Sangamon, Schuyler, and Scott Counties and consultation to full-time health departments: Counties—Adams, Calhoun, Christian, Greene, Jersey, Menard, Montgomery, Morgan, and Pike.

Region IV:

Marie A. Gronlund, R.N., Acting Health Officer, 2125

South First Street, Champaign, Illinois 61820. Counties of Champaign, Clark, Coles, Cumberland, Edgar, Ford, Kankakee and Moultrie and consultation to full-time health departments: Counties—DeWitt-Piatt, Douglas, Effingham, Iroquois, Livingston, Macon, McLean, Shelby, and Vermilion; Urban—Champaign-Urbana Public Health District.

Region V:

Arthur E. Sulek, M.D., M.I.H., Acting Health Officer, 5415 North University Avenue, Peoria 61614. Counties of Bureau, Henderson, Knox, Marshall, McDonough, Putnam, Stark, Tazewell, Warren, and Woodford and consultation to full-time health departments: Counties—Fulton, Henry, Mercer, Peoria and Rock Island; City—Peoria.

Region VI:

Arthur E. Sulek, M.D., M.I.H., Health Officer, 4302 North Main Street, Rockford, 61103. Counties of Boone, LaSalle and Ogle and consultation to full-time health departments: Counties—Carroll, DeKalb, JoDaviess, Lee, Stephenson, Whiteside and Winnebago; Urban—Hygienic Institute (LaSalle, Oglesby, Peru) and Rockford.

Region VII:

George H. Agate, M.D., M.S.P.H., Health Officer, 48 West Galena Boulevard, Aurora 60504. Kane County and consultation to full-time health departments: Counties—Cook, DuPage, Grundy, Kendall, Lake, McHenry and Will; Urban—Berwyn Township Public Health District, Evanston-North Shore, Oak Park, Skokie, Stickney Township Public Health District.

County and Multiple-County Health Departments

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Cook County, John B. Hall, M.D., M.P.H., Director, 1425 S. Racine Ave., Chicago 60608

North District, 1401 Oakton St., Des Plaines 60018

South District 51 E. 154 St., Harvey 60426

Southwest District, 5410 W. 95th St., Oak Lawn 60453

West District, 1907-09 Rice St., Melrose Park 60160

DeKalb County, Mrs. Audre Anderson, R.N., B.S., Acting Administrator, 1731 Sycamore Rd., DeKalb 60115

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Piatt County Office, Courthouse, Monticello 61856

Douglas County, Mary Lou Pflum, R.N., B.S.N., Acting Administrator, P.O. Box 382, Tuscola 61953

DuPage County, Charles A. Lang, M.D., M.P.H., Health Officer, 222 E. Willow Ave., Wheaton 60187

Effingham County, Peter C. Supan, M.D., M.P.H., Health Officer, 112 E. Section Ave., Effingham 62401

Egyptian (Gallatin-Saline-White Counties), Allen Kelly,

B.S., Acting Administrator, 1333 Locust St. Eldorado 62930

White County, 208 N. Church, Carmi 62821

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Mrs. John F. Jacobs, Springfield
 Esther O. Kegan, Chicago
 Helen Levin, Champaign
 Robert W. Mitchler, Oswego
 Earl Moldovan, Salem
 John Moutoussamy, Chicago
 Morris E. Nelson, Altona
 Ross Reardon, Springfield
 Harold D. Schwartz, Lincolnwood
 Rev. Rudolph Shoultz, Springfield
 Honorable Fred Smith, Chicago
 Ross Tarr, Peoria Heights
 Nathan Willens, Skokie
 Marie Woolen, East St. Louis

Providers

C. Norman Andrews, Chicago
 Ben Behrent, Pawnee
 Dr. Ralph E. Dolkart, Evanston
 Don C. Frey, Evanston

William J. Greek, D.D.S., Springfield
 John B. Hall, M.D., Chicago
 Jerome Hammerman, Chesterton
 Joseph B. Helms, D.V.M., Edwardsville
 Dr. Robert R. J. Hilker, Chicago
 Helen Hotchner, R.N., LaGrange
 Thaddeus P. Kawalek, Chicago
 David Kinzer, Chicago
 Dr. LeRoy Levitt, Chicago
 Dr. Edward Lis, Flossmoor
 Virginia Ohlson, R.N., Chicago
 Dr. Eric Oldberg, Lake Forest
 Dr. Edward Perry, Salem
 Dr. Edward Piszczek, Chicago
 James W. Roodhouse, East Peoria
 Dr. Robert Rutherford, Peoria
 Joseph Settler, D.P.M., Tremont
 Dr. Vivien P. Siegel, East St. Louis
 Philip G. Thomsen, M.D., Dolton
 William H. Weed, Ottawa

HOSPITALS WITH SPECIAL TYPE OF SERVICE

		Type of Service
CASEYVILLE (St. Clair)	Pleasant View Sanitorium (E-70)	TB
CHICAGO (Cook)	*Booth Memorial Hospital (B-19)	Maternity
	*Schwab Rehabilitation Hospital (B-88)	Rehabilitation
	*Chicago Eye, Ear, Nose and Throat Hospital (C-37)	EENT
	*Chicago State Tuberculosis Sanitarium (I-346)	TB
	*The Children's Memorial Hospital (B-236)	Pediatric
	Halco Hospital, Inc. (C-10)	Alcoholic
	*LaRabida Jackson Park Sanitarium (B-104)	Pediatric
	*Martha Washington Hospital (B-40)	Chronic
	*Municipal Contagious Disease Hospital (D-100)	Alcoholic
	*Municipal Tuberculosis Sanitarium (D-760)	Contagious Disease
	*Rehabilitation Institute of Chicago (B-71)	TB
	St. Vincent's Infant Hospital (B-65)	Rehabilitation
	*Shriners Hospital for Crippled Children (B-68)	Pediatric
DECATUR (Macon)	Macon County Tuberculosis Sanitorium (E-40)	Orthopedic, Pediatric
HINSDALE (Cook)	*The Suburban Cook County Tuberculosis Sanitarium District (G-209)	TB
JOLIET (Will)	Sunny Hill Sanitorium (E-41)	TB
MACKINAW (Tazewell)	Oak Knoll Sanitorium (E-40)	TB
MOOSEHEART (Kane)	Moosehart Hospital (B-43)	Pediatric

MOUNT VERNON (Jefferson)	*Mount Vernon State Tuberculosis Sanitarium (I-125)	TB
OAK FOREST (Cook)	Oak Forest Hospital (E-2,400)	Chronic
OTTAWA (LaSalle)	*Ottawa General Hospital (C-51)	Chronic
PEORIA (Peoria)	*Peoria Municipal Tuberculosis Sanitarium (D-77)	TB
ROCKFORD (Winnebago)	Rockford Municipal Tuberculosis Sanitarium (D-45)	TB
ROCK ISLAND (Rock Island)	*Rock Island County Tuberculosis Sanitorium (E-71)	TB
SPRINGFIELD (Sangamon)	*St. John's Sanitorium (B-50)	TB
URBANA (Champaign)	Outlook Champaign County Tuberculosis Sanitorium (E-25)	TB
WAUKEGAN (Lake)	*Lake County Tuberculosis Sanatorium (E-90)	TB
WEDRON (LaSalle)	St. Joseph's Health Resort and Sanitarium (B-94)	Medical- Chronic

Number in parenthesis indicates number of
beds in hospital. Initial preceding number refers
to the type of control, as follows:

A—Corporation

B—Non-profit association or corporation

C—Privately owned and operated

D—City

E—County

F—Hospital District

G—Sanitarium District

H—Township

I—State

J—Federal

*Medicare Certified

STATE MENTAL HOSPITALS

ALTON (Madison)	JACKSONVILLE (Morgan)
Alton State Hospital (1,216)	*Jacksonville State Hospital (1,305)
ANNA (Union)	KANKAKEE (Kankakee)
Anna State Hospital (1,206)	*Kankakee State Hospital (2,561)
CHICAGO (Cook)	MANTENO (Kankakee)
Chicago State Hospital (1,958)	Manteno State Hospital (5,907)
*Illinois State Psychiatric Institute (310)	MENARD (Randolph)
EAST MOLINE (Rock Island)	Illinois Security Hospital (260)
*East Moline State Hospital (1,255)	PEORIA (Peoria)
ELGIN (Kane)	*Peoria State Hospital (1,545)
Elgin State Hospital (4,128)	TINLEY PARK (Cook)
GALESBURG (Knox)	Tinley Park Mental Health Center (523)
*Galesburg State Research Hospital (1,481)	

PRIVATE MENTAL HOSPITALS

AURORA (Kane)	DES PLAINES (Cook)
*Mercyville Institute of Mental Health (B-120)	*Forest Hospital (C-105)
CHICAGO (Cook)	ELGIN (Kane)
*Fairview Hospital (C-100)	*Resthaven Hospital (C-100)
*Nicholas J. Pritzker Center (B-40)	FOREST PARK (Cook)
*Pinel Hospital Inc. (B-70)	*Riveredge (C-145)
*Ridgeway Hospital (B-99)	

STATE SCHOOLS FOR MENTALLY RETARDED

CENTRALIA (Marion)

Warren G. Murray Children's Center (700)

CHICAGO (Cook)

*Illinois State Pediatric Institute (264)

DIXON (Lee)

Dixon State School (4,245)

DWIGHT (Livingston)

William W. Fox Children's Center (250)

HARRISBURG (Saline)

A. L. Bowen Children's Center (244)

LINCOLN (Logan)

Lincoln State School (4,819)

LICENSED CLINICAL LABORATORIES

ALTON

Stromsdorfer Medical Laboratory
604 E. Broadway, Rm. 101 62002

ARCOLA

Oak Park Medical Laboratory
207 East Main 61910

ARGO

*Argo Clinical Laboratory
6252 Archer Road 60501

ARLINGTON HEIGHTS

*Village Medical Laboratory
1009 S. Evergreen 60005
*Arlington Medical Laboratory
1430 N. Arlington Heights Road 60004

AURORA

*Clinical Laboratory
143 South Lincoln 60505
Physicians Clinical Laboratory
57 E. Downer Place 60504

BARRINGTON

*Barrington Medical Laboratory
606 S. Northwest Hwy. 60010

BELLEVILLE

*St. Clair Medical Laboratory
301 W. Lincoln Street 62221

BENTON

Benton Medical Center Laboratory
205 Bailey Lane 62812

BERKELEY, CALIFORNIA

Solano Laboratories—Clinical Laboratory Affiliates
2113 Dwight Way 94701

BERWYN

Cermak Road Medical Laboratories
7120 W. Cermak Road 60402
*Kenilworth Laboratory
6905-A West Cermak Road 60402
Public Health District, Town of Berwyn
6600-26th Street 60402
Stickney Township Public Health Laboratory
6721 West 40th Street 60402

BLOOMINGTON

*Bloomington Cornbelt Bio-Chemical, Inc.
705 North East 61701
Clinical and Surgical Pathology Laboratory
211 E. Jefferson St. 61701

Medical Arts Building Laboratory
2304 E. Oakland Ave. 61701

E. M. Stevenson, M.D. Laboratory
Suite 418 Unity Bldg. 61701

*Hans H. Stroink, M.D. Clinical Laboratory
214 Unity Building 61701

BROADVIEW

*Broadview Physicians Laboratory
2200 W. Roosevelt Rd. 60153

CANTON

Coleman Clinic Laboratory
175 South Main 61520

CENTRALIA

Centralia X-ray Laboratories
418 South Poplar 62801
Medical Arts Laboratory, Inc.
210 E. Third Street 62801

CHAMPAIGN

*Doctors Building Laboratory
301 E. Springfield 61820

CHICAGO

*A & D Medical Laboratory, Inc.
3848 West 63rd Street 60629
A-C Medical Laboratory
3512 West 26th Street 60623
Abel Laboratory, Inc.—Bio-Tech.
25 E. Washington St. 60602
*Accurate Medical Laboratory, Inc.
5959 N. Washtenaw Ave. 60645
*Almar Clinical Laboratory
2457 W. Peterson Ave. 60645
American Clinical Testing Laboratory
30 W. Washington St. 60602
*Apogee Medical Laboratories, Inc.
5962 N. Lincoln Ave. 60645
*Arcade Clinical Laboratory
6904 N. Sheridan Rd. 60626
Archer Clinical Laboratory
4176 Archer 60632
*Associated Medical Laboratory, Inc.
4753 N. Broadway 60604
*Auburn Clinical Laboratory
946 West 79th Street 60620
Augusta Clinical Laboratory
3454 N. Lincoln Ave. 60657
*Austin Clinical Laboratory
5679 W. Madison St. 60644
*Avenue Medical Laboratory
11318 S. Michigan Ave. 60628

- *Bel-Aire Medical Building Laboratory
8501 S. Cottage Grove Ave. 60619
- Beverly Clinical Laboratory
9451 South Hoyne 60620
- Beverly Laboratory Building, Inc.
8710 S. Ashland Ave. 60620
- *Beverly Sheridan Laboratory, Inc.
9449½ S. Ashland Ave. 60620
- *Brooks Clinical Laboratory
4006 Milwaukee Avenue 60641
- *Aaron S. Cahan, M.D. Laboratory
4010 W. Madison Street 60624
- Callahan Clinic Laboratory
4849 W. Fullerton Ave. 60639
- Campos Laboratory
1608 N. Milwaukee 60647
- *Central Doctors Medical Laboratory
2715 N. Central Ave. 60639
- Central Medical Building Laboratory
3929 N. Central Ave. 60634
- Century Medical Laboratory
8348 Stony Island Ave. 60617
- *Chatham Avalon Clinical Laboratory
8222 S. Martin Luther King, Jr. Drive 60619
- *Chemical Consulting Corporation
6018 W. Fullerton Ave. 60639
- Chicago Board of Health—Division of Laboratories
Lower Level—Chicago Civic Center 60602
- Chicago Park District Medical Laboratory
425 East 14th Blvd. 60605
- Chicago Health Center Laboratory
15 S. Wacker Drive 60619
- Chicago Physicians Medical Laboratory, Inc.
4555 N. Broadway 60640
- *Clearing Industrial Clinic, Inc.
5548 W. 65th Street 60638
- *Colonial Medical Arts Laboratory
2024 West 79th Street 60620
- *Community Medical Laboratory
3613 W. Roosevelt Rd. 60624
- Continental Insurance Company
360 W. Jackson Blvd. 60606
- Corbett Clinic Medical Laboratory
1380 W. Lake Street 60607
- Crawford Medical Arts Laboratory
6449 S. Pulaski Road 60629
- Cytodiagnostic Laboratory, Inc.
25 E. Washington 60602
- Division Medical Laboratory, Inc.
2625 W. Division St. 60622
- Division Clinical Laboratory
5025 W. Division St. 60651
- Doctors Building Laboratory
2800 West 87th 60652
- *Doctors Medical Laboratory, Inc.
11440 S. Michigan Ave. 60628
- *Drexel Home, Inc.
6140 S. Drexel Avenue 60637
- Field Clinic Laboratory
4600 N. Ravenswood Ave. 60640
- Fordon Medical Laboratory
2656 W. 63rd Street 60629
- *Foster Western Laboratories, Inc.
5214 N. Western Ave. 60625
- Francis Laboratory
122 S. Michigan Ave. 60603
- *Gerber X-Ray and Clinical Laboratory
2400 West Devon 60645
- *Gerson Clinical Laboratory
1 North Pulaski 60625
- Grant Hospital Laboratory
551 W. Grant Place 60614
- Greer Clinical Laboratories, Inc.
4013 N. Milwaukee 60641
- *Highland Medical Laboratory
7922 S. Ashland Ave. 60620
- Highland View Medical Center
8556 S. Ashland Ave. 60620
- *Humboldt Clinical Laboratory
2018 S. Ashland Ave. 60608
- *Hyde Park Medical Laboratory
5240 South Harper 60615
- Illinois Clinical Laboratory
55 E. Washington St. 60602
- Irving Park Clinical Laboratory
3959 N. Lincoln Ave. 60613
- *K & K Clinical Laboratory
5935 W. Addison 60634
- *Kendon Medical Laboratory, Inc.
8625 S. Cicero Avenue 60658
- Laboratory of Union Health Service
1634 West Polk 60612
- *Letho Clinical Laboratories
1325 S. Racine Avenue 60608
- Logan Square X-Ray and Clinical Laboratory, Inc.
2815 N. Kimball 60618
- *Marquette Medical Laboratory
6132 South Kedzie 60629
- *Mart X-Ray Laboratory Company
7-110 Merchandise Mart 60654
- *Maryhaven Medical Laboratory, Inc.
8700 S. Dante Avenue 60619
- *Mason-Barron Pathology Clinical Laboratory
2056 North Clark Street 60614
- *Medic Clinical Laboratory
6317 S. Western Avenue 60636
- *Medical Association of Chicago Clinic Laboratory
3233 South King Drive 60616
- *Medical Center Clinical Laboratory
3528 N. Ashland Ave. 60657
- Mediscreen Laboratory
5 South Wabash 60603
- *Metro Laboratories
1737 W. Howard St. 60626
- Metro Laboratories
9204 Commercial Ave. 60617
- *Metro Laboratories
2376 E. 71st Street 60649
- Metro Laboratories
1525 E. 53rd Street 60615
- *Metro Laboratories
30 N. Michigan Avenue 60602
- Metro Laboratory
104 South Michigan 60603
- Meyer Medical Group
10444 S. Kedzie Avenue 60655
- Meyer Medical Group
653 West 79th Street 60620
- *Midwest Cytology Laboratory
5707 North Ashland 60626
- Milwaukee Avenue X-Ray and Clinical Laboratory
1217 N. Milwaukee Ave. 60622
- *Molay Medical Laboratory
185 North Wabash 60601

*Murphy Uptown Clinical Laboratory, Inc.
4753 North Broadway 60640

*North Kimball Medical Laboratory
1579 N. Milwaukee Ave. 60622

Northwest Medical Laboratory
2006 West Chicago 60622

Norwest Medical Laboratory
2336 West Chicago 60622

*Ogden Hill Medical Laboratory
3451 West 63rd Street 60629

*Omens Medical Building X-Ray and Clinical
Laboratory
5720 West North Avenue 60639

*P. M. D. Clinical Laboratory
2017 West 95th Street 60643

*Park View Home Medical Laboratory
1401 N. California 60622

*Park-Grove Medical Laboratory
8048 S. Cottage Grove 60619

Parke DeWatt Laboratories, Inc.
111 North Wabash Ave. 60602

Parkside Clinical Laboratory
7915 S. King Drive 60619

*Parkway Laboratory
408 E. Marquette Road 60637

*Pasco Medical Laboratories
55 E. Washington St. 60602

*Peterson Western Clinical Laboratory
2424 West Peterson 60645

*Physicians and Surgeons Laboratory
6710 West North Ave. 60635

Post Graduate Hospital Laboratory
2400 S. Dearborn Street 60616

Robard Corporation
30 North Michigan 60602

*S & S Medical Laboratory, Inc.
532 East 47th Street 60653

*Sarian Medical Laboratory
6257 South Archer Ave. 60638

*Sauganash X-Ray and Medical Laboratory, Inc.
4833 W. Peterson 60646

*South Central Medical Laboratory
5050 South State 60609

*South East Medical Laboratory
1832 East 87th Street 60617

Southwestern Laboratory, Inc.
7939 S. Western Avenue 60620

Thompson X-Ray and Clinical Laboratory
1150 North State Street 60610

*Thornburg Clinical Laboratory
841 East 63rd Street 60637

*Thornburg Clinical Laboratory
720 N. Michigan Ave. 60611

Richard W. Tiecke, D.D.S.
211 E. Chicago Avenue 60611

United Air Lines Medical Department
P.O. Box 66100 60666

*United Medical Laboratories, Inc.
8 S. Michigan Ave., Room 1412 60603

*University Laboratory
5 South Wabash Avenue 60603

*West Lawn Medical Laboratory
4255 West 63rd Street 60629

*Westerly Medical Laboratory
10404 South Western 60643

*Westridge Clinical Laboratory
6450 N. California 60645

*Westside Clinical Laboratory
3808 W. Roosevelt Rd. 60624

*Zeitlin X-Ray and Clinical Laboratory
2800 Milwaukee Avenue 60618

*200 Clinical Laboratory
200 East 75th Street 60619

*2011 Clinical Laboratory, Inc.
2011 East 75th Street 60649

*63rd Medical Laboratory
749 West 63rd Street 60621

*95th Street X-Ray and Clinical Laboratory
243 West 95th Street 60628

United Airlines Medical Department Laboratory
O'Hare Field Station, Box 66140 60666

CICERO

*Suburban Laboratory, Inc.
2137 S. Lombard Avenue 60650

COLLINSVILLE

Appleton Laboratory
416 E. Main Street 62201

DEKALB

DeGraffenried and Fisher
720 Haish Boulevard 60115

*DeGraffenried Fisher Laboratory
1838 Sycamore Road 60115

DeKalb Medical Center Laboratory
901 North First Street 60115

DECATUR

*Central Clinical Laboratory
1314 North Main 62526

Macon County Health Department Laboratory
1085 South Main Street 62521

DEERFIELD

*Colrad Clinical Laboratory
747 Deerfield Road 60614

DES PLAINES

*Dempster-Lyman Clinical Laboratory and X-Ray
2404 Dempster 60016

*Deridge Clinical Laboratory
3200 Dempster Street 60016

Fahey Medical Center
581 Golf Road 60016

DETROIT, MICHIGAN

Central Laboratories, Inc.
312 David Whitney Bldg. 48226

DIXON

*Physicians Medical Laboratory
101 West First Street 61021

DOWNERS GROVE

Downers Grove Medical Laboratory
4333 Main Street 60515

DuPage Medical and Research Laboratory
1043 Curtiss 60515

EAST ST. LOUIS

*Appleton Laboratory
234 Collinsville Ave. 62201

*Clinical Laboratory
4601 State Street 62201

ELGIN

- *Fox Valley Medical Laboratory
860 E. Summit Street 60120

ELK GROVE VILLAGE

- Medical Laboratory and X-Ray, Inc.
762 Arlington Hts. Rd. 60007

ELMHURST

- Cytopathology Laboratory
135 S. Kenilworth 60126
- *Haven Clinical Laboratory
103 Haven Road 60126
- Pasco Medical Laboratory
533 W. North Avenue 60126
- *Sandahl Medical Laboratory
135 S. Kenilworth 60126

EVANSTON

- *Cos Building Laboratory
2500 Ridge Avenue 60201
- *Gyne-Cytology Laboratory, Inc.
636 Church Street 60201
- *Pasco Medical Laboratories
636 Church Street 60201
- Evanston-North Shore Health Dept.
Box 870 60201

EVERGREEN PARK

- *Acorn Laboratories
2658 West 95th Street 60642
- *Anatomic and Clinical Pathology
P.O. Box 42919 60642
- Evergreen Park Medical Laboratory
9760 South Kedzie Ave. 60642
- *Francisco Medical Laboratory
9450 S. Francisco Ave. 60642
- Mosquera Clinical Laboratory
3830 West 95th Street 60642
- *North Beverly Clinical Laboratory
3759 West 95th Street 60642

FOREST PARK

- *Bowers Laboratory
7318 Madison Street 60130

FRANKLIN PARK

- *Franklin Park Medical Laboratory, Inc.
9711 Grand 60131

FREEPORT

- Freeport Clinic Laboratory
222 W. Exchange Street 61032
- Freeport Medical Clinic
324 West Galena 61032
- Northwest Illinois Laboratory
319 North West Avenue 61032

GALESBURG

- *Galesburg Clinic Laboratory
320 N. Kellogg Street 61401

GLEN ELLYN

- Glen Ellyn Clinic Laboratory
454 Pennsylvania Avenue 60137
- Glen Ellyn Medical Laboratory
526 Crescent Boulevard 60137

GLENVIEW

- *Northwest Suburban X-Ray and Clinical Laboratory
924 Waukegan Road 60025

GODFREY

- Doctors Laboratory
1312 West Delmar 62035

HARVEY

- Community Medical Center
15900 Carol Avenue 60426
- *Graham Clinical Laboratory
468 East 147th Street 60426
- Weiss Clinical Laboratory
15318 Center Avenue 60426

HIGHLAND PARK

- *Highland Park Medical Laboratory
1950 Sheridan Road 60035

HINSDALE

- *Pasco Medical Laboratories
40 South Clay Street 60521

HOFFMAN ESTATES

- *Twinbrook Medical Laboratory
Golf & Roselle Road 60172

JACKSONVILLE

- Medical Development Corporation
1440 West Walnut 62650

JERSEYVILLE

- J. R. Miller Medical Laboratory
123A West Pearl Street 62052

JOLIET

- *Associate Pathologists
2112 West Jefferson 60435
- *Central Laboratory
57 W. Jefferson Street 60431
- Joliet Clinical Laboratory
59 W. Clinton Street 60431
- *Osler Laboratories, Inc.
120 North Scott Street 60431
- *Prescription Shop Laboratory
55 N. Ottawa Street 60431
- *Woodruff Laboratory, Inc.
250 N. Ottawa Street 60431

KANKAKEE

- *Medical Center Laboratory
1309 East Court Street 60901
- Physicians Medical Laboratory, Inc.
555 S. Schuyler Avenue 60901

LAGRANGE

- *LaGrange Medical Building Laboratory
47 South Sixth 60525

LAGRANGE PARK

- Village Market Medical Laboratory
360 Sherwood Court 60525

LASALLE

- Hygienic Institute Laboratory
151 Fifth Street 61301
- *Medical Laboratory
555-2nd Street 61301

LANSING

- *DeGraff Clinical Laboratory
3341 Ridge Road 60438

LEROY

- V. K. Pliura, M.D. Laboratory
101 West School 61752

LOMBARD

- Lombard Chiropractic Clinical Laboratory
200 E. Roosevelt Road 60148

MACOMB

McDonough District Hospital Laboratory
525 East Grant Street 61455

MARSEILLES

Carr Medical Laboratory
Main Street 61341

MAYWOOD

*Joslyn Clinic Laboratory
1908 St. Charles Road 60153

MC HENRY

*McHenry Medical Group
1110 N. Green Street 60050

MELROSE PARK

Broadway Medical Laboratory, Inc.
1812 North Broadway 60160
*Delm Medical Laboratory
1900 West Iowa 60160

MENDOTA

Mendota Community Hospital Laboratory
Memorial Drive 61342

MOLINE

*Martin Clinical Laboratory
1520-7th Street 61265
Moline Public Hospital Laboratory
635-10th Avenue 61265

MORRISTOWN, NEW JERSEY

Bio-Analytical Associates, Inc.
36 Elm Street 07960

MORTON GROVE

*Sommerfeld Medical Laboratory, Inc.
5818 Dempster Street 60053

MOUNT PROSPECT

*Mount Prospect Clinical Laboratory
321 West Prospect Ave. 60056
*Prospect Clinical Laboratory
1060 W. Northwest Hwy. 60056
Professional Arts Medical Laboratory
221 West Prospect 60056

MUNDELEIN

Menolasino Laboratory, Inc.
1352 Armour Boulevard 60060

NORTHBROOK

Industrial Bio-Test Laboratories, Inc.
1810 N. Frontage Road 60062
*Northbrook Clinical and X-Ray Laboratory
1775 Walters 60062

OAK LAWN

Stickney Township Public Health Laboratory
5635 State Road 60459

OAK PARK

*American Medical Laboratory
6441 W. North Avenue 60302
*Arms Medical Laboratory
414 S. Oak Park Avenue 60302
*James B. Hartney, M.D.
410 Lake Street 60302
*McGregor Laboratory
6144 W. Roosevelt Road 60304

Medical Arts Clinic Laboratory

715 Lake Street 60301
Tarlow Clinical Laboratory
6525 W. North Avenue 60302
*Hill Clinical Laboratory, Inc.
1011 Lake Street 60301

OAKBROOK

*Pasco Medical Laboratories
120 Oak Brook Ctr. Mall 60521

OGLESBY

*Physicians Clinical Laboratory
338 East Walnut 61348

OLYMPIA FIELDS

Athenia Park Medical and X-Ray Laboratory
2601 W. Lincoln Hwy. 60461

PALOS HEIGHTS

*Palos Medical Laboratory
12150 S. Harlem Avenue 60463

PARK FOREST

Medical and Dental Building Clinical Laboratory
23450 S. Western Avenue 60466
*South Suburban Medical Laboratory
2448 Western Avenue 60466

PARK RIDGE

Park Ridge Clinical Laboratory
3 South Prospect Ave. 60068
Plaza Laboratories Ltd.
101 S. Washington St. 60068

PEKIN

*Medical Laboratory, The
519 Margaret 61554

PEORIA

*M. B. Clinical Laboratory Corp.
818 West Main 61606
*Medical Center Laboratories
416 St. Marks Court 61603
Peoria Department of Health
2116 N. Sheridan Road 61604
*W. H. Schwarzendruber Laboratory
300 E. War Memorial Dr. 61614

ROCKFORD

*Medical Laboratory of Pathology
1221 E. State Street 61108
Rockford Health Department Laboratory
425 E. State Street 61104

ROLLING MEADOWS

Rolling Meadows Professional Laboratory
3407 Kirchoff Road 60008

ROSELLE

Sylvester Clinical Laboratory
225 E. Irving Park Road 60172

SANDWICH

Sandwich Comm. Hospital Laboratory
11 East Pleasant 60548

SKOKIE

Harry H. Hetz, M.D. Pathology Laboratories
4240 Dempster Street 60076
*Lincoln Medical Laboratory
4535 Oakton Street 60076

4801 Church Street 60076
*Pasco Medical Laboratories
64 Old Orchard 60076

SPRINGFIELD

*Capitol Clinical Laboratories
1104 South 2nd Street 62704
Doctors Park Medical Laboratory
701 North Walnut 62702
*Physicians Medical Laboratory
501 N. 6th-Box 2178 62703
*Springfield Clinic
1025 South 7th Street 62703

STREATOR

Streator Medical Clinic
Westgate Plaza 61364

SUMMIT

Dwan Medical Center Laboratory
7450 West 63rd Street 60501

SYCAMORE

DeGraffenried and Fisher
Sycamore Municipal Hosp. 60178

URBANA

Carle Clinic Laboratory
602 W. University 61801

VILLA PARK

*Ardmore Pharmacy, Inc.
317 S. Ardmore 60181
Villa Medical Arts Laboratory
10 E. Central Blvd. 60181

*Besley-Waukegan Clinic
215 N. Sheridan Road 60085
*Physicians and Surgeons Laboratory
1616 Grand Avenue 60085
Standard Bio-Medical Laboratories, Inc.
521 Greenwood Avenue 60085
X-Ray and Clinical Laboratory
4 South Genesee 60085

WESTCHESTER

Westchester Community Clinic
1938 S. Mannheim 60153

WHEATON

*Mason-Barron Pathology Laboratory
200 E. Willow 60187

WILMETTE

*Wilmette Clinical Laboratory
165 Green Bay Road 60091

WILMINGTON

Clinical Laboratory and X-Ray
107 S. Water Street 60481

WINNETKA

*Clinical-Technical Laboratory, Inc.
1048 Gage Street 60093
*Winnetka Clinical Laboratory
725 Elm Street 60093

ZION

*Zion Clinic Laboratory
2629 Sheridan Road 60099

*Medicare Certified.

APPROVED CHRONIC RENAL DIALYSIS CENTERS AND DIRECTORS

Michael Reese Hospital and Medical Center
29th Street and Ellis Avenue
Chicago, Illinois 60616
Dr. Alan Kanter
Presbyterian-St. Luke's Hospital
1753 West Congress Parkway
Chicago, Illinois 60612
Dr. Franklin D. Schwartz
Washington University School of Medicine
(Barnes Hospital)
660 South Euclid Avenue
St. Louis, Missouri 63110
Dr. Neal S. Bricker
Memorial Hospital
Renal Unit
First and Miller Streets
Springfield, Illinois 62701
Dr. Alton Morris
St. Francis Hospital
523 Northeast Glen Oak
Peoria, Illinois 61603
Dr. James D. Myers
University of Illinois Research
and Educational Hospitals
840 South Wood Street
Chicago, Illinois 60612
Dr. Clarence L. Gantt
Passavant Memorial Hospital
303 East Superior Street
Chicago, Illinois 60611
Dr. Francesco del Greco

Mount Sinai Hospital Medical Center
Fifteenth and California Avenues
Chicago, Illinois 60608
Dr. George Dunea
University of Chicago Hospitals and Clinics
(includes LaRabida Sanitarium)
950 East 59th Street
Chicago, Illinois 60637
Dr. Frank P. Stuart and Dr. Adrian I. Katz
West Suburban Hospital
518 North Austin Boulevard
Oak Park, Illinois 60302
Dr. Robert C. Muehrcke
University Hospitals Renal Section
Department of Medicine
1300 University Avenue
Madison, Wisconsin 53706
Dr. Arvin B. Weinstein
Evanston Hospital
2650 Ridge Avenue
Evanston, Illinois 60201
Dr. Bernard Adelson
West Suburban Kidney Center, S.C.
1011 Lake Street
Room 410
Oak Park, Illinois 60301
Dr. Robert C. Muehrcke
Rockford Memorial Hospital
2300 N. Rockton Avenue
Rockford, Illinois
Dr. Ewald T. Sorensen

APPROVED CHRONIC RENAL DIALYSIS UNITS AND DIRECTORS

The Children's Memorial Hospital
2300 Children's Plaza
Chicago, Illinois 60614
Dr. Gilbert Given

Rockford Memorial Hospital
2300 North Rockton Avenue
Rockford, Illinois
Ewald T. Sorensen, M.D.

Galesburg Cottage Hospital
674 North Seminary Street
Galesburg, Illinois 61401
Dr. Agha Babanoury

Used as a satellite by Centers:
Freeport Clinic
222 West Exchange Street
Freeport, Illinois 61032
Dr. Thomas A. Haymond

For further information contact:
Mrs. Ruth S. Shriner, ACSW
Illinois Department of Public Health
535 West Jefferson Street
Springfield, Illinois 62706
Phone: (217) 525-6564

ARTIFICIAL KIDNEY CENTERS

As of Aug. 7, 1969, these centers may be contacted regarding renal dialysis.

Children's Memorial Hospital
2300 Children's Plaza
Chicago

Phone: 348-4040
Person in Charge: Alan Siegel, M.D.
Location in Hosp: Nephrology

Edgewater Hospital
5700 N. Ashland Avenue
Chicago

Phone: UP 8-6000
Person in Charge: Rogelio Riera, M.D.
Location in Hosp: Surgery

Michael Reese Hospital
2929 South Ellis Avenue
Chicago

Phone: 791-2000
Person in Charge: Dr. Allan Kanter
Location in Hosp: Department of Medicine
Division of Renal Medicine

Mt. Sinai Hospital
California Ave. at 15th Street
Chicago

Phone: 277-4000
Person in Charge: Dr. George Dunea
Location in Hosp: Department of Medicine

Passavant Memorial Hospital
303 E. Superior Street
Chicago

Phone: WH 4-4200
Person in Charge: Francesco del Greco, M.D.
Location in Hosp: Artificial Kidney

Presbyterian-St. Lukes Hospital
1753 West Congress Parkway
Chicago

Phone: 942-5000
Person in Charge: Robert M. Kark, M.D.
Location in Hosp: Division of Medicine

University of Chicago Hospital
950 E. 59th Street
Chicago

Phone: MU 4-6100
Persons in Charge: Dr. Frank P. Stuart and
Dr. Adrian Katz
Location in Hosp: Department of Medicine

University of Illinois Research
and Educational Hospital
840 South Wood Street
Chicago

Phone: 663-7591
Person in Charge: Clarence Gantt, M.D.
Location in Hosp: Clinical Research Center

St. Joseph Hospital
277 Jefferson Avenue
Elgin

Phone: 741-5400
Person in Charge: Charles K. Bobelis, M.D.
Location in Hosp: Artificial Kidney Dept.

Evanston Hospital
2650 Ridge Avenue
Evanston

Phone: 492-2000
Person in Charge: Dr. Bernard Adelson
Location in Hosp: Kidney Dialysis Dept.

Galesburg Cottage Hospital
674 N. Seminary Street
Galesburg

Phone: 343-4121
Person in Charge: Agha Babanoury, M.D.

Riverside Hospital
350 N. Wall
Kankakee

Phone: 933-1671
Person in Charge: Dr. Eugene Anderson
Location in Hosp: Intensive Care

West Suburban Hospital
518 North Austin Boulevard
Oak Park

Phone: EU 3-6200
Person in Charge: Robert Muehrcke, M.D.
Location in Hosp: Kidney Dialysis Room-2nd Fl.

St. Francis Hospital
530 N.E. Glen Oak
Peoria

Rockford Memorial Hospital
2300 N. Rockton Avenue
Rockford, Illinois

Swedish-American Hospital
1316 Charles Street
Rockford

Memorial Hospital
First & Miller Streets
Springfield

Barnes Hospital
Barnes Hospital Plaza
St. Louis, Missouri

St. Francis Hospital
825 Good Hope Street
Cape Girardeau, Missouri

Phone: 674-7731 Ext. 605
Person in Charge: Dr. J. D. Myers
Location in Hosp: Chronic Dialysis Unit
Phone: 968-6861
Person in Charge: Dr. Ewald T. Sorensen

Phone: 968-6898
Person in Charge: Dr. Robert Henry
Location in Hosp: Intensive Care

Phone 528-2041
Person in Charge: Dr. Alton Morris
Location in Hosp: Intensive Care

Phone: 367-6400
Person in Charge: Neal Bricker, M.D.
Location in Hosp: Second Floor

Phone: 334-4461
Person in Charge: Sister M. Venard
Location in Hosp: Surgery

POISON CONTROL CENTERS IN ILLINOIS

For further information contact:
Norman J. Rose, M.D., M.P.H., Chief
Bureau of Hazardous Substances and Poison
Control
Illinois Department of Public Health
535 W. Jefferson
Springfield 62706
Phone: (217) 525-7747

AURORA

Copley Memorial Hospital
Lincoln & Weston Avenues
896-4611, Ext. 725
St. Charles Hospital
400 E. New York Street
897-8714, Ext. 50

BELLEVILLE

Memorial Hospital
4501 North Park Dr.
233-7750, Ext. 250 & 251

BELVIDERE

Highland Hospital
1625 S. State St.
547-5441, Ext. 367

BERWYN

MacNeal Memorial Hospital
3249 S. Oak Park Ave.
484-2211 Ext. 311, 312, 314

BLOOMINGTON

Mennonite Hospital
807 North Main St.
828-5241, Ext. 311
St. Joseph Hospital
2200 E. Washington
829-9481, Ext. 352, 354

CAIRO

St. Mary's Hospital
2020 Cedar St.
734-2400, Ext. 42, 45

CANTON

Graham Hospital Association
210 W. Walnut St.
647-5240, Ext. 230

CARBONDALE

Doctors Memorial Hospital
404 W. Main St.
457-4101

CARTHAGE

Memorial Hospital
End South Adams St.
357-3133, Ext. 57

CENTRALIA

St. Mary's Hospital
400 N. Pleasant Ave.
532-6731, Ext. 626, 629

CHAMPAIGN

Burnham City Hospital
311 E. Stoughton St.
337-2533

CHANUTE AIR FORCE BASE*
United States Air Force Hospital
893-3111, Ext. 6234

CHESTER
Memorial Hospital
1900 State St.
826-2367, Ext. 44

CHICAGO
Children's Memorial Hospital
2300 Children's Plaza
348-4040, Ext. 338
Cook County Hospital
1825 West Harrison St.
633-6542
University of Illinois Hospitals
840 South Wood St.
663-7297
Mercy Hospital
2510 Martin Luther King Dr.
842-4700, Ext. 281
Michael Reese Hospital
29th Street & Ellis Ave.
791-2261
Mt. Sinai Hospital
15th & California
277-4000, Ext. 297
Municipal Contagious Disease San.
3026 South California Ave.
247-5700
Presbyterian-St. Lukes Hospital
(Master Chicago Center for information,
treatment & reference on poisoning)
1753 W. Congress Parkway
942-5969
Resurrection Hospital
7435 West Talcott Ave.
774-8000, Ext. 235, 236
Wyler Children's Hospital
950 E. 59th St.
684-6100 Ext. 6231, 6232

DANVILLE
Lake View Memorial Hospital
812 N. Logan Ave.
443-5221
St. Elizabeth Hospital
600 Sager St.
442-6300

DECATUR
Decatur Memorial Hospital
2300 N. Edward St.
877-8121, Ext. 675-676
St. Mary's Hospital
1800 E. Lake Shore Dr.
429-2966, Ext. 640

DES PLAINES
Holy Family Hospital
100 North River Road
299-2281, Ext. 856

*Limited for treatment of military personnel and families, except for indicated emergencies.

EAST ST. LOUIS
Christian Welfare Hospital
1509 Illinois Ave.
874-7076, Ext. 232
St. Mary's Hospital
129 North 8th St.
274-1900, Ext. 204

EFFINGHAM
St. Anthony's Memorial Hospital
503 North Maple St.
342-2121, Ext. 67

ELGIN
St. Joseph's Hospital
277 Jefferson Ave.
741-5400, Ext. 65, 69
Sherman Hospital
934 Center St.
742-9800, Ext. 682

ELMHURST
Memorial Hospital of DuPage County
315 Schiller St.
833-1400, Ext. 551, 552

EVANSTON
Community Hospital
2040 Brown Ave.
869-5044, Ext. 54, 58
Evanston Hospital
2650 Ridge Ave.
492-6460
St. Francis Hospital
355 Ridge Ave.
492-2440

EVERGREEN PARK
Little Company of Mary Hospital
2800 W. 95th St.
422-6200, HI5-6000, Ext. 211

FAIRBURY
Fairbury Hospital
519 South Fifth St.
692-2346

FREEPORT
Freeport Memorial Hospital
420 South Harlem Ave.
233-4131, Ext. 228

GALENA
The Galena Hospital District
Summit Street
777-1340

GALESBURG
Galesburg Cottage Hospital
674 North Seminary St.
343-4121, Ext. 356
St. Mary's Hospital
239 South Cherry St.
343-3161, Ext. 210

GRANITE CITY

St. Elizabeth's Hospital
2100 Madison Ave.
876-2020, Ext. 224

HARVEY

Ingalls Memorial Hospital
15510 Page Ave.
333-2300, Ext. 787, 792

HIGHLAND

St. Joseph Hospital
1515 Main St.
654-2171, Ext. 243

HIGHLAND PARK

Highland Park Hospital Foundation
718 Glenview Ave.
432-8000, Ext. 561, 562, 563

HINSDALE

Hinsdale San. & Hospital
120 North Oak St.
323-2100, Ext. 336

HOOPESTON

Hoopeston Community Memorial Hospital
701 E. Orange
283-5531

JACKSONVILLE

Passavant Memorial Area Hospital
1600 West Walnut St.
245-9541, Ext. 222

JOLIET

St. Joseph's Hospital
333 N. Madison St.
725-7133, Ext. 679, 680, 681, 682
Silver Cross Hospital
600 Walnut St.
727-1711, Ext. 731

KANKAKEE

Riverside Hospital
350 N. Wall St.
933-1671, Ext. 606
St. Mary's Hospital
150 South Fifth St.
939-4111, Ext. 735

KEWANEE

Kewanee Public Hospital
719 Elliott St.
853-3361, Ext. 219

LAKE FOREST

Lake Forest Hospital
660 North Westmoreland Road
234-5600, Ext. 608

LASALLE

St. Mary's Hospital
1015 O'Connor Ave.
223-0607

LIBERTYVILLE

Condell Memorial Hospital
Cleveland & Stewart Aves.
362-2900, Ext. 325-326

LINCOLN

Abraham Lincoln Memorial Hospital
315 Eighth St.
732-2161, Ext. 346

MACOMB

McDonough District Hospital
525 East Grant St.
833-4101

MAYWOOD

Loyola University Hospital
2160 S. 1st Ave.
531-3886 (24-hour direct line)

MATTOON

Mem. Dist. Hosp. of Coles County
2101 Champaign Ave.
234-8881, Ext. 43, 29

McHENRY

McHenry Hospital
3516 West Waukegan Road
385-2200, Ext. 614

MELROSE PARK

Westlake Hospital
1225 Superior St.
681-3000, Ext. 226, 239

MENDOTA

Mendota Community Hospital
Memorial Drive
7461, Ext. 20

MOLINE

Moline Public Hospital
635-10th Ave.
762-3651, Ext. 232

MONMOUTH

Community Memorial Hospital
W. Harlem Ave.
734-3141, Ext. 224

MOUNT CARMEL

Wabash General Hospital
1418 College Drive
262-4121, Ext. 231

MOUNT VERNON

Good Samaritan Hospital
605 North Twelfth St.
242-4600, Ext. 303,

NAPERVILLE

Edward Hospital
South Washington St.
355-0450, Ext. 326

NORMAL

Brokaw Hospital
Virginia at Franklin Ave.
829-7685, Ext. 274

OAK LAWN

Christ Community Hospital
4440 West 95th St.
423-7000, Ext. 659, 600, 661

OAK PARK

West Suburban Hospital
518 North Austin Blvd.
383-6200, Ext. 6747

OLNEY

Richland Memorial Hospital
800 East Locust St.
395-2131

OTTAWA

Ryburn Memorial Hospital
701 Clinton St.
433-3100

PARK RIDGE

Lutheran General Hospital
1775 Dempster St.
692-2210, Ext. 1220, 1460

PEKIN

Pekin Memorial Hospital
14th & Court
347-1151, Ext. 233, 241

PEORIA

Methodist Hospital
221 Northeast Glen Oak Ave.
685-6511, Ext. 250
Proctor Community Hospital
5409 North Knoxville Ave.
691-4702, Ext. 791, 792
St. Francis Hospital
530 Northeast Glen Oak Ave.
674-2943

PERU

Peoples Hospital
925 West Street
223-3300, Ext. 55, 40

PITTSFIELD

Illini Community Hospital
640 West Washington St.
285-2115, Ext. 238, 213

PRINCETON

Perry Memorial Hospital
530 E. Park Ave.
875-2811, Ext. 311

QUINCY

Blessing Hospital
1005 Broadway
223-5811, Ext. 211, 212
St. Mary's Hospital
1415 Vermont St.
223-1200, Ext. 275

ROCKFORD

Rockford Memorial Hospital
2400 North Rockton Ave.
968-6861, Ext. 441

St. Anthony's Hospital

5666 E. State St.
226-2041

Swedish-American Hospital

1316 Charles St.
968-6898, Ext. 602

ROCK ISLAND**St. Anthony's Hospital**

767-30th St.
226-2041

ST. CHARLES**Delnor Hospital**

975 North Fifth Ave.
584-3300, Ext. 218, 229, 286

SCOTT AIR FORCE BASE

USAF Medical Center
256-7595

SPRINGFIELD

Memorial Hospital
First and Miller Sts.
528-2041, Ext. 333

St. John's Hospital
701 E. Mason St.
544-6451, Ext. 375

STREATOR

St. Mary's Hospital
111 E. Spring St.
672-3189, Ext. 221

URBANA

Carle Hospital
611 W. Park St.
337-3313
Mercy Hospital
1400 West Park Ave.
337-2131

WAUKEGAN

St. Therese Hospital
West Waukegan St.
688-6470-71
Victory Memorial Hospital
1324 North Sheridan Road
688-4181

WOODSTOCK

Memorial Hospital for McHenry County
527 West South St.
338-2500, Ext. 32

ZION

Zion-Benton Hospital,
2500 Emmaus Ave.
872-4561, Ext. 240

PACKAGED DISASTER HOSPITALS IN ILLINOIS

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
Emergency Health Section
535 W. Jefferson
Springfield, Illinois
Phone: (217) 525- 4659 or -4812

ALTON

St. Joseph's Hospital

ANNA

Anna State Hospital

AURORA

Copley Memorial Hospital

BELVIDERE

St. Joseph's Hospital

BENTON

Franklin Hospital

CAIRO

St. Mary's Hospital

CANTON

Graham Hospital

CARLINVILLE

Carlinville Hospital

CENTRALIA

St. Mary's Hospital

CHARLESTON

Community Memorial Hospital

CHESTER

Chester Memorial Hospital

CHICAGO HEIGHTS

St. James Hospital

DANVILLE

Lakeview Memorial
St. Elizabeth's Hospital

DECATUR

Decatur Memorial Hospital

DEKALB

DeKalb Public Hospital

DES PLAINES

Forest Hospital
Holy Family Hospital

DIXON

Dixon State School

DU QUOIN

Marshall Browning Hospital

ELGIN

Elgin State Hospital
Sherman Hospital

ELMHURST

DuPage Memorial Hospital

EVANSTON

St. Francis Hospital

FREEPORT

Freeport Memorial

GALESBURG

Cottage Hospital
Galesburg State Hospital

HARRISBURG

Harrisburg Hospital

HIGHLAND PARK

Highland Park Hospital

HILLSBORO

Hillsboro Hospital

JACKSONVILLE

Jacksonville State Hospital

JERSEYVILLE

Jersey Community Hospital

JOLIET

Silver Cross Hospital

KANKAKEE

Kankakee State Hospital
St. Mary's

LAKE FOREST

Lake Forest Hospital

LINCOLN

Abraham Lincoln Memorial Hospital
Lincoln State School

LITCHFIELD

St. Francis Hospital

MANTENO

Manteno State Hospital

MATTOON

Memorial Hospital of Coles County

McHENRY

McHenry Hospital

METROPOLIS

Massac Memorial Hospital

MONMOUTH

Monmouth Hospital

MURPHYSBORO

St. Joseph Memorial Hospital

MORRIS

Morris Hospital

NORMAL

Brokaw Hospital

OAK FOREST

Oak Forest Hospital

OAK LAWN

Christ Community Hospital

OLNEY

Richland Memorial Hospital

OTTAWA

Ryburn Hospital

PARIS

Paris Hospital

PEKIN

Pekin Memorial Hospital

PEORIA

St. Francis Hospital

PONTIAC

St. James Hospital

PRINCETON

Perry Memorial Hospital

QUINCY

St. Mary's Hospital

RED BUD

St. Clement's Hospital

ROCKFORD

Swedish-American Hospital

RUSHVILLE

Sara D. Cubertson Hospital

ST. CHARLES

Delnor Hospital

SANDWICH

Sandwich Community Hospital

STERLING

Community General Hospital

URBANA

Carle Hospital

WAUKEGAN

St. Therese

WATSEKA

Iroquois Hospital

WINFIELD

Central DuPage Hospital

WOOD RIVER

Wood River Hospital

ZION

Zion-Benton Hospital

IDPA TO USE NEW CPT IN 1971

The Illinois Department of Public Aid is currently re-programming its computer to process payments to physicians according to procedural codes listed in the new **AMA Current Procedural Terminology**, second edition (the "blue" book). The revision is expected to be completed and ready for use early in 1971.

The new coding procedure uses a five-digit code (instead of the four-digit one now in use) which provides for greater accuracy in the listing of services provided. Other improvements include increased specificity, the addition of many new procedures and listings by system or region.

This new edition of the CPT is now available from the American Medical Association, Circulation and Records Department, 525 North Dearborn St., Chicago, Illinois 60610. Price \$2.00. Each physician is urged to order his copy now so as to become familiar with the changes and additions; however, **they are asked NOT to use this coding at the present time**. Additional information concerning the effective date for its use will be published in the **Illinois Medical Journal**, and the Public Aid Department will notify each participating physician by letter.

Medical Legal Information

(Prepared by ISMS Legal Counsel, Frank M. Pfeifer)

LEGAL SERVICES OF ISMS

The Illinois State Medical Society retains a General counsel and occasionally uses the services of special counsel in implementing its various programs. Legal advice is given to the state society and its components as organizations, but is not available to individual members.

It is intended that this article give general information only; for any specific problem consultation should be had with the physician's individual attorney.

The legal department of the Society can answer

specific questions propounded by officers of county medical societies in Illinois, which are part of and make up the state society, if the questions are of interest to the membership as a whole.

Although the Society and its counsel cannot provide personal advice to ISMS members, it is to every physician's advantage to acquaint himself with as much general medical-legal knowledge as possible. The following section, therefore, is devoted to this kind of information.

HOW TO SET YOUR AFFAIRS IN ORDER

It is suggested that the physician, during his lifetime, compile in one place needed information about the location of important records and papers. The Illinois State Medical Society urges that a will be prepared by a competent attorney and said will be re-evaluated by an attorney whenever there is a material change in any circumstances or in state law.

The physician should, of course, leave information about insurance, real estate, and bank accounts just as everyone else does, but he has additional responsibilities peculiar to his profession. He should leave instructions for:

1. Temporary coverage of his practice. Some arrangement with a colleague should be made immediately for hospitalized patients, and others should be notified of the doctor's death.

2. Patient records, which should be carefully

preserved for a minimum of 10 years and for 25 years, if possible. Contents of the records should be turned over to another physician upon written request.

3. Return of unused narcotics to the Treasury Department, the narcotics tax stamp and order book to the Internal Revenue Service, and retention of the narcotics ledger for two years.

4. Disposal of his practice. If it is to be sold, rapid action is advised as value is lost quickly. Equipment is best disposed of with the sale of the practice.

5. Benefits that may be due survivors from unused insurance premiums, Blue Cross-Blue Shield, Veterans Administration, or Social Security.

As soon as practical after death, the attorney who will handle the estate should be contacted and his advice followed thereafter.

LEGAL LIABILITY OF PHYSICIANS

The legal liability of physicians is a question on which much has been written. It has also been the topic of discussion at many meetings of medical and medical-legal groups. However, because of the grave nature of the problem, the Illinois State Medical Society's legal counsel believes that the subject cannot be overemphasized.

Statistics prove that the number of malpractice and general liability suits against physicians is on the increase. This does not mean that physicians are becoming less skillful or more careless in their diagnosis and treatment; it probably means that physicians are being affected by the tremendous growth there has been recently in all types of personal injury litigation.

More people than ever before are receiving medical attention and more are starting lawsuits against physicians when recovery is less than complete.

Liability Insurance

For this reason, it is essential that every physician carry liability insurance to protect him against all possible claims. The physician

should be aware, however, that there are some inadequate policies on the market today and an attorney should be consulted before contracting for insurance that may not cover the doctor's particular circumstance. Additional coverage insofar as limits are concerned is relatively inexpensive and should be carried in sufficient amount to cover all possibilities.

Prior to the 1967 Session of the General Assembly of Illinois, the greatest recovery that could be had for wrongful death was \$30,000 but this limitation has now been removed and there is no limit in the amount which may be recovered in the case of wrongful death. This means that in malpractice cases resulting in death, the verdict could be extremely high. It is therefore recommended that all physicians take a look at their malpractice insurance policies to determine that they are properly covered and in adequate limits. The cost of this insurance does not materially increase with the increase in limits and therefore extremely high limits are suggested.

A physician today is a "sitting duck" for a lawsuit even though he may in no way be guilty

of negligence. And lawsuits to defend, no matter how meritorious, require the expenditure of time and money.

Legal implications in this field are wide, but basically the physician is liable for his own negligent acts and the negligent acts of all his employees. In the case of a partnership, he is also liable for the negligent acts of his partners.

While the right kind of insurance in sufficient amount will protect the physician financially, steps should be taken by all doctors to help minimize the filing of lawsuits of this kind and to work for reduction in the number of guilty verdicts being obtained.

The American Medical Association has prepared, and has available for distribution, several interesting pamphlets and papers on this subject. The pamphlet entitled, "Professional Liability and the Physician," reprinted from the February, 1963 issue of the *Journal of the American Medical Association*, contains this statement:

Physician's Responsibility

"In the final analysis, the physician himself must share the responsibility for the continuing existence of the unpleasant professional liability situation. Many physicians have been satisfied to pay their professional liability insurance premiums and thereafter to sit back complacently, doing nothing until they become a target. Every physician must be brought to realize that this money payment is only part of his insurance program; a much more important part is his contribution of time, study, and attention to put into effect all possible measures to safeguard the patient, himself, and his colleagues. Professional liability is in no sense merely an insurance problem. It is a medical problem and must be combatted by members of the medical profession."

The AMA pamphlet goes on to say that "prevention is the best possible defense against claims and suits" and lists these 20 prevention "commandments":

1. The physician must care for every patient with scrupulous attention given to the requirements of good medical practice.

2. The physician must know and exercise his legal duty to the patient.

3. The physician must avoid destructive and unethical criticism of the work of other physicians.

4. The physician must keep records which clearly show what was done and when it was done, which clearly indicate that nothing was neglected, and which demonstrate that the care given met fully the standards demanded by the law. If any patient discontinues treatment before he should, or fails to follow instructions, the records should show it; a good method is to preserve a carbon copy of the physician's letter advising the patient against the unwise course.

5. A physician must avoid making any state-

ment which constitutes, or might be construed as constituting an admission of fault on his part. He should instruct employees to make no such statements.

6. The physician must exercise tact as well as professional ability in handling his patients, and should insist on a professional consultation if the patient is not doing well, if the patient is unhappy and complaining, or if the family's attitude indicates dissatisfaction.

7. The physician must refrain from over-optimistic prognoses.

8. The physician must advise his patients of any intended absences from practice and recommend, or make available, a qualified substitute. The patient must not be abandoned.

9. The physician must unfailingly secure an "informed" consent (preferably in writing) for medical and surgical procedures and for autopsy.

10. The physician must carefully select and supervise assistants and employees and take great care in delegating duties to them.

11. The physician should limit his practice to those fields which are well within his qualifications.

12. The physician must frequently check the condition of his equipment and make use of every available safety installation.

13. The physician should make every effort to reach an understanding with his patient in the matter of fees, preferably in advance of treatment.

14. The physician must realize that it is dangerous to diagnose or prescribe by telephone.

15. The physician should not sterilize a patient solely for the patient's convenience except after a reasonably complete explanation of the procedure and its risks and possible complications and after obtaining a signed consent from the patient and from the patient's spouse if the patient is married. Such sterilization is a crime in Connecticut, Kansas, and Utah and should not be performed in those states. Eugenic sterilization should be performed only in conformity with the law of the state, if any. Sterilization for therapeutic purposes may lawfully be performed with the informed consent of the patient and preferably with the informed consent of the patient's spouse, if the patient is married.

16. Except in an actual emergency situation which makes it impossible to avoid doing so, a male physician should not examine a female patient unless an assistant or nurse, or a member of the patient's family is present.

17. The physician should exhaust all reasonable methods of securing diagnosis before embarking upon a therapeutic course.

18. The physician should use conservative and less dangerous methods of diagnosis and treatment wherever possible, in preference to highly toxic agents or dangerous surgical procedures.

19. The physician should read the manufacturer's brochure accompanying a toxic agent to be used for diagnostic or therapeutic purposes, and, in addition, should ascertain the customary dosage or usage in his area.

20. The physician should be aware of all the known toxic reactions to any drug he uses, together with the proper methods for treating such reactions.

The general counsel for the Illinois State Medical Society has given the following suggestions on how to avoid and defeat malpractice suits:

1. Physicians should conduct their practice in hospitals so that they comply with and live up to the standards for hospital accreditation of the American Hospital Association, the hospital regulations adopted by the State Department of Public Health under the Hospital Licensing Act and the by-laws of the hospital in which they are practicing.

2. Physicians should keep up on modern medicine in the fields in which they practice so they are conversant with and use the latest proven developments.

3. Physicians should call in specialists whenever the need arises.

4. Physicians should provide for automatic consultation in all serious cases—it cannot be disputed that any physician being called on to defend his treatment in court is in a much better position if he can also bring forth as a witness the physician who reviewed the case and consulted with him, or the specialist in a given field called in by him.

5. Hospital records and those of the physician should be kept in such manner and in such detail as will be meaningful and show that adequate medical procedures were followed. It should be remembered that frequently cases are not filed until some time after the alleged injury took place and sometimes do not come to trial for several years thereafter.

6. All cases should be treated in such a manner and records kept as if the case would result in a malpractice suit and would not come to trial for a considerable period of time after the alleged injury had taken place.

7. Physicians should carry adequate malpractice insurance.

The Illinois State Medical Society has published a pamphlet, "The Physician's Liability in Patient Care," which is available for distribution to any physician who does not have a copy and desires one.

Consent by Minors to Medical Treatment and Operations

The general law in Illinois is that a minor cannot give legal consent or waive any rights which he has under the law. In the year 1961, the Illinois legislature made an exception to this

rule by specifically providing that consent to the performance of medical or surgical treatment by a licensed physician could be executed by a married person who is a minor or a pregnant woman who is a minor and shall not be voidable because of such minority. This act further provides that any parent who is a minor may consent to the performance upon his or her child of medical or surgical procedures by a licensed physician and that the consent shall not be voidable because of such minority.

In the year 1969, the Illinois legislature made further exception to this rule by providing that:

1. Anyone 18 years of age or older may give binding legal consent to all medical and surgical procedures. (Consent for all operations or any unusual, improper or dangerous medical procedures should be in writing regardless of age.)

2. It is no longer necessary for either hospital or physician to obtain consent from parent or guardian before rendering emergency treatment to a minor, if the obtaining of the consent might adversely affect the condition of the minor's health.

3. Any one over the age of 18 years may donate blood without the consent of parent or guardian.

4. Any minor 12 years of age or older having a venereal disease may now give consent to the furnishing of medical care related to the diagnosis or treatment of such disease. All such cases shall be reported by the physician to the State Department of Public Health or the local Board of Health. Any physician providing diagnosis or treatment for a minor having a venereal disease may in his discretion inform the parent or guardian of such minor as to the treatment given or needed.

5. Physicians are now specifically authorized to provide birth control services including medical and pharmacological treatment and information to any minor:

- a) who is married; or
- b) who is a parent; or
- c) who is pregnant; or
- d) who has the consent of his parent or legal guardian; or
- e) as to whom the failure to provide such services would create a serious health hazard; or
- f) who is referred for such services by a physician, clergyman or a planned parenthood agency.

Employment Contract Between Physician and Patient

The relationship between a physician and a patient is one of contractual relationship and, therefore, a physician is under no legal requirement to accept anyone as a patient unless he so desires. This rule is true in the case of an

emergency even though no other physician is available.

Legally, a physician has the right to refuse treatment in the case of an accident or other emergency and could not in any way be held liable for refusing to administer aid. (*This is strictly the legal answer and does not involve the moral or ethical question.*) The rendering of such services as may be necessary in the case of an emergency does not of itself give rise to the relationship of physician and patient and the physician is under no obligation to continue treatment beyond the emergency.

The physician in rendering emergency treatment, however, must use the same degree of skill and care as required in other cases, taking into consideration conditions at the scene of the accident.

Continuation of Treatment

A physician or surgeon, on undertaking an operation or treatment, is under the duty, in the absence of an agreement limiting the service, of continuing his attendance, after the operation or first treatments, as long as the case requires attention; and a surgeon, in his treatment subsequent to an operation, is required to exercise reasonable and ordinary skill and care.

The failure to give needed continued care under an obligation to do so constitutes negligence or malpractice. The obligation of continuing attention can be terminated only by the cessation of the necessity which gave rise to the relationship of physician and patient, by mutual consent of the parties, by the discharge of the physician by the patient, or by the physician's withdrawing from the case after giving the patient reasonable notice so as to enable him to secure other medical attendance.

A physician has the legal right to withdraw from a case if the patient breaks the contract by failure to follow the medical advice or treatment and direction of the physician, but the relationship cannot be terminated until the physician has advised the patient of his withdrawal from the case and has allowed the patient a reasonable length of time to procure another doctor.

Written Notice

What is reasonable notice to the patient depends upon the circumstances of each case. Factors which must be taken into consideration are the condition of the patient, the size of the community, and the availability or other physicians. In order to be completely safe, prior to withdrawal from the case, the physician should advise the patient in writing of his intent to withdraw, his reasons therefor, and the fact that he will make available the patient's case history and information regarding diagnosis and treatment to the new physician when selected by the patient.

Should the patient return to the original physician stating that he has been unable to procure other medical aid, treatment should not be refused until a replacement has been obtained.

A physician has the right to leave his practice temporarily if he makes provisions for the attendance of a competent physician during his absence. This notice, which again preferably should be in writing, should be in sufficient time so that patients can obtain replacements of their own choice if they do not desire to consult the physician temporarily handling the practice of the absent physician.

GOOD SAMARITAN ACT

The 1965 Legislature passed the so-called "Good Samaritan Bill" providing that any physician, who in good faith, provides emergency care without a fee at the scene of a motor vehicle accident or in case of nuclear attack shall not as a result of his acts or omissions, except in the case of gross willful or wanton negligence, be liable for damages. (Paragraph 2a of Chapter 91, Illinois Revised Statutes, 1967.)

In 1969 this Act was further amended to extend the physician's immunity to any type of accident.

HOSPITAL PATIENT RECORDS

The 1969 session of the General Assembly passed a new act which provides that all private or public hospitals shall, upon the demand of any patient, allow his physician or attorney to examine his hospital records and to make copies thereof. The only exception is in connection with records relating to psychiatric care. Demands for such records must be in writing and shall be delivered to the administrator of the hospital.

HOSPITAL EMERGENCY ROOMS

For many years Illinois law has required that both public and private hospitals, where surgical operations are performed, must provide emergency medical treatment or first aid to any person who applies for same in the case of injury or acute medical condition where the same is liable to cause death or severe injury or serious illness. This act provides penalties for non-compliance.

In the 1969 session of the Legislature this act was amended by Senate Bill 568 by allowing two or more hospitals to combine for the purpose of providing this emergency service upon an area wide or community basis but with the requirement that the plan of consolidation be reduced to writing and approved by the Illinois Department of Public Health prior to its implementation.

INTERNAL REVENUE CODE

It should be evident to the busy physician that

it is just as unwise for him to be his own tax consultant as it is for every man to be his own doctor. The physician is well aware that in seeking to keep abreast of all of the ramifications and developments of modern medicine, he has a burden that is becoming increasingly difficult to sustain and that he has very little time to devote to subjects as complex as taxation, which is rightfully the province of his accountant and lawyer.

Taxation in the United States is complex and many tax matters have no particular application to the medical profession as such. However, the doctor as a citizen should be aware that he is greatly affected by a subject so varied and so complicated that the statutes themselves require some 1,500 pages to be set forth. And he should know that sections 1(a) through 8023(b) are printed in a size of type that should be of some benefit in fees to practitioners who concern themselves with the human eye. Surely the point that physicians are well advised to place their problems with accounting and legal advisors is further exemplified by such facts as the following:

Regulations implementing the Internal Revenue Act require some 9,700 pages for them to be spelled out and that, in order to designate the different regulations, the government needs to entitle the regulations as Regulation Section 1.0-1 through Regulation Section 301.770-11.

Just as the patient would be so much better served if he saw his doctor regularly before difficulties became advanced, so the physician's interests would be better served if he would seek advice on income and estate tax problems before the fact, rather than after problems have arisen.

PROCEDURES AND REPORTS IN CONTROL OF NARCOTIC DRUGS

Physicians are subject to control by both the state of Illinois and the federal government in relation to narcotic drugs. The numerous provisions of the federal regulations are set forth in a fairly lengthy pamphlet entitled, "Regulations No. 5 Relating to the Importation, Manufacture, Production, Sale, etc., of Opium, Coca Leaves, Isonipocaine or Opiates," which was reprinted April 1, 1957, and is available at a cost of 45 cents through the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. This is published by the Bureau of Narcotics of the U. S. Treasury Department.

The state of Illinois' "Uniform Narcotic Drug Act" has been in effect since Jan. 1, 1958. It is found in paragraphs 22-1 through 22-49, inclusive, Chapter 38 of Illinois Revised Statutes, 1967. The Division of Narcotic Control's current rules and regulations to implement the Act have been in effect since Apr. 1, 1960. They cover such matters as prescriptions and official forms therefor, emergencies excusing use of other than official prescription forms, reporting or loss or theft of

such prescription blanks, records to be kept by the physician, dispensing of hypodermic syringes and needles, prescribing procedures in hospitals, and other subjects related to narcotic drugs. The Act and the rules and regulations are available at no cost through the Division of Narcotic Control, 623 E. Adams St., Springfield.

Further, the state of Illinois has had in effect since Jan. 1, 1960, a "Uniform Drug, Device and Cosmetic Act." Its rules and regulations control such things as the keeping of adequate records, for a period of two years, of all purchases and dispositions of dangerous drugs as such drugs are defined by the Act. A publication containing the Act and the pursuant rules and regulations is also available through the Division of Narcotic Control in Springfield.

All physicians are urged to have in their possession copies of both the state and federal narcotic control acts and the rules and regulations implementing them. As these laws and regulations are changed from time to time, every effort should be made to have the current rules.

PROCEDURES AND REPORTS AS TO COMMUNICABLE DISEASES

In order to be conversant with the presently governing rules and regulations as to the control of communicable diseases and the physician's duties as to reports and procedures in relation to these afflictions, it is suggested that the physician apply to the Department of Public Health of the State of Illinois at Room 500, State Office Building, Springfield, for the publication entitled, "Rules and Regulations for the Control of Communicable Diseases," which was revised July 1, 1965.

ANATOMICAL GIFT ACT

The law, in the State of Illinois, allows an individual to leave his body or particular parts thereof, for medical science by means of his will or a written statement carried upon his person or found among his effects. The next of kin may also donate all or any part of the body for medical science. The Illinois law, authorizing the above, is set out at Paragraphs 551 through 560 of Chapter 3, Illinois Revised Statutes, 1969.

The Illinois State Medical Society has prepared forms which may be used by both the donor himself or by the next of kin. Copies of these forms are available at headquarters office in Chicago.

Anatomical Gift By a Living Donor

(1)
I, _____, do hereby give
(2)
_____ to
(3)
_____ for the following

(4)
purpose:

.....
IN WITNESS WHEREOF, I have hereunto set
(5)
my hand and seal this day of,
A.D. 19.....

(6)
.....(SEAL)
Signed, sealed, published and declared by the
(1)

said in the presence
of us, who at his (her) request, in his (her)
presence and in the presence of each other have
hereunto subscribed our names as attesting wit-
nesses, believing him (her) to be of sound and
disposing mind and memory, free from any undue
influence, and to know the objects of his (her)
bounty and affection.

(7)
.....
(7)
.....

Instructions

1. Insert name of person making gift.
2. Insert: "my whole body"; or list specific or-
gans and parts to be given.
3. Insert name and address of a physician; or
a hospital, or a medical institution to receive
the gift.
4. Insert: "any purpose authorized by law;" or
"a transplantation" or "therapy;" or "re-
search;" or "medical education."
5. Insert date of the signing of this card.
6. Signature of donor.
7. Signature and address of two necessary wit-
nesses.

Anatomical Gift by Next of Kin Or Other Authorized Person

- I. I (we) are the surviving:
1. ☐ Spouse and adult sons and daughters
 2. ☐ Both parents or surviving parent
 3. ☐ Adult brothers and sisters
 4. ☐ Guardian of the person of the de-
cedent
 5. ☐ Person authorized or under obliga-
tion to dispose of the body
of, who died on the
..... day of, 19..... in the County
of, State of,
and
- II. I (we) hereby give:
- ☐ The entire body of the deceased.
 - ☐ Any specific organs or parts of the body
of the deceased designated by the donee.
 - ☐ The following organs or parts of the
body of the deceased:

.....
TO:

(Insert name and address of a physi-
cian; a hospital; or a medical institution)
for one of the following purposes:

- ☐ Any purpose authorized by law.
- ☐ A transplantation.
- ☐ Therapy.
- ☐ Research.
- ☐ Medical education.

III. I (we) hereby represent and certify that I
(we) are the person(s) authorized to execute
this authorization in accordance with the or-
der of priority specified in the Uniform Ana-
tomical Gift Act as listed in #I above.

.....
Name Relationship to deceased City & State
.....
.....

Instructions

This form must be signed by the survivor or
survivors in the order of priority, Nos. 1 through
5, with all persons in any category being required
to sign. (EXAMPLE: Form to be signed by liv-
ing spouse and all living adult sons and daugh-
ters; but if no survivors in this category, then go
on to No. 2 under which surviving parents or
parent must sign but if no one in this category,
go to No. 3, where all surviving brothers and sis-
ters must sign; and in the same manner through
Categories 4 and 5 if necessary.)

If additional signature lines are needed, they
may be added at the bottom of the form.

AUTOPSY

In Illinois, the heirs and next of kin can bring
an action for mutilation of the body in those cases
where an autopsy is performed without authority
or permission. In order to avoid the possibility of
liability, autopsies should only be performed, in
Illinois, when ordered by the coroner or upon
written consent given by the next of kin. The cor-
oner may order an autopsy directly against the
wishes of the next of kin.

MEDICAL CORPORATIONS

In 1963 the Illinois Legislature for the first time
authorized the formation of medical corpora-
tions (Paragraph 631 through 647 Chapter 32
Illinois Revised Statutes, 1969). Under this act
one or more physicians licensed to practice medi-
cine may organize as an Illinois business cor-
poration. All officers, directors and shareholders
of the corporation must be licensed under the
Medical Practice Act.

After the passage of this Act, Internal Revenue
took the position that physicians were not en-
titled to any tax benefits thereunder. In those
cases appealed, the courts ruled that such benefits
should be allowed.

In the summer of 1969 Internal Revenue re-

treated from this position and now is holding that medical corporations authorized under state law are valid and that the tax benefits accrue to the members.

The question as to whether or not a medical corporation is advisable depends upon each in-

dividual situation but in most instances, tax dollars probably can be saved by the formation of such a corporation. It is suggested that physicians, whether practicing individually or in a group, consult their accountants and attorneys to determine if such incorporation would be profitable.

STATUTE OF LIMITATIONS IN MALPRACTICE

The Supreme Court of Illinois recently handed down a decision in the case of *Lipsey vs. Michael Reese Hospital and Dr. Gerald Menaker*, (1970) in which the Statute of Limitations in malpractice cases was extended and, in some instances, nullified. The law in Illinois, until this decision, was that an action of malpractice had to be commenced within two years after the alleged negligent act took place and if the lawsuit was not filed within this time, it was barred.

Both the physician and the hospital moved to strike the complaint as being barred by the two year Statute of Limitation, but the Supreme Court, in reversing all prior Illinois law on this subject, held that it would be unrealistic and unfair to bar the cause of action of the injured party before the negligence had been discovered. The Court then specifically held that the lawsuit could be filed any time within two years after the act of negligence became known. This so-called "discovery rule" has been upheld in other jurisdictions but this was the first time that it has been applied in malpractice cases in Illinois.

In all cases before the Illinois Supreme Court,

either side may ask for a rehearing after a case has been decided.

If the decision is not changed on rehearing it will mean that there is no longer any limitation insofar as malpractice is concerned, as lawsuits may be brought at any time within two years after the alleged act of negligence has been discovered by the patient. The specific holding of the Illinois Supreme Court is that, in a medical malpractice case, the cause of action accrues at the time of the discovery of the negligence and not at the time of its occurrence.

In 1965, the Illinois Legislature added a new section to the Limitations Act, which provided that if in the course of any medical or surgical treatment or operation, any foreign substance was permitted to remain within the body which caused harm, the Statute of Limitations would not begin to run until the negligence was discovered, but the Act further provided that no action could be commenced beyond ten years after the negligent act. While this Statute is not an issue in this case the courts will, in the future, probably adopt the discovery rule in this, categorically, and eliminate the ten year limitation provision.

General Health Services Information

Health services information not listed in this Reference
Issue can be obtained by contacting the following:

The Chicago Hospital Council
840 N. Lake Shore Drive
Chicago 60611

Department of Public Health
503 State Office Building
Springfield 62706

Department of Mental Health
401 S. Spring Street
Springfield 62706

Department of Children & Family Services
Room 404, New State Office Building
Springfield 62706

Department of Public Aid
618 E. Washington Street
Springfield 62706

Department of Registration & Education
160 N. LaSalle Street
Chicago 60601

Department of Allied Medical Professions & Services
American Medical Association
535 N. Dearborn Street
Chicago 60610

Division of Vocational Rehabilitation
623 E. Adams Street
Springfield 62706

Illinois Hospital Association
840 N. Lake Shore Drive
Chicago 60611

Illinois League for Nursing
6355 Broadway
Chicago 60626

Metropolitan Chicago Nursing Home Association
43 E. Ohio Street, Suite 1206
Chicago 60611

Directories are available for the following:

Dentists

American Dental Directory. Available from the American Dental Association, 211 E. Chicago, Chicago, Illinois. Annual. \$25. Lists members and nonmembers, military dentists, dental schools, associations linked to ADA, examining boards, health agencies, state dental organizations, etc. For Dentists, lists name, address, birth year, dental school, degree, specialty, etc.

Osteopaths

Yearbook and Directory of Osteopathic Physicians. American Osteopathic Association, 212 East Ohio Street, Chicago. Annual. \$25 for first copy, \$12.50 each additional copy. Covers both members and nonmembers, colleges, associated osteopathic hospitals. For Osteopaths, lists name, address, birth year, osteopathic school, specialty, etc.

Physicians and Surgeons

AMA Geographic Register of Physicians. AMA, 525 North Dearborn, Chicago. Every 2 years. \$90. Latest volume April, 1970. Covers both members and nonmembers, colleges, etc. For Medical Doctors, lists name, address, birth year, type of practice, specialty, medical education, license year, boards passed, society memberships, etc.

Podiatrists

Desk Reference. American Podiatry Association, 3301 16th Street NW. Washington, D.C. Annual. About \$25. (Free to advertisers; write "Business office".) Includes alphabetic and geographic listing of podiatrists, affiliated organizations, accredited colleges, therapeutic indices and a catalog of audiovisual, informational and educational materials. For Podiatrists, lists name, address, birth year, podiatric specialty, etc.

Drugstores

Hayes Drugstore Directory. Edward N. Hayes, Publisher, 206 West 4th Street, Santa Ana, California. Annual. \$36 if buy regularly; \$40 one time basis. Lists retail drugstores, estimating volume and credit rating. A list of wholesale druggists is also included.

Internships and Residencies

Directory of Approved Internships and Residencies, AMA, 525 North Dearborn, Chicago. Published in the Fall of the year. Free.

Nursing Homes

U.S. Guide to Nursing Homes. Published by Grosset & Dunlap, Inc., New York City. Each of 3 volumes covers a geographic section of U.S.; \$2.95 per volume. Name and address of home, number of beds, medical services available, recreation and entertainment. (Even a section on how to tell someone they are entering a nursing home without feeling guilty. Perhaps a little too consumerish for some, but very worthwhile for the public relations of nursing homes.)

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Sunday — November 15, 1970

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I plan to attend the ISMS Leadership Conference on "Health Care Delivery In the 70's" on November 15, 1970, at the Continental Plaza Hotel in Chicago. Enclosed is my check for \$_____ covering _____ lunch(es) (\$5.50 per person).

Name _____

Address _____

City _____ Zip _____

Mail to: Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Illinois 60601

Meeting Memos

October 17-18—University of Kentucky

Workshop on Skin Problems
University of Kentucky, College of Medicine, Lexington, Kentucky

October 20-22—American College of Emergency Physicians

2nd Annual Scientific Assembly
Sahara Hotel, Las Vegas, Nevada

October 23—Northwestern University

Symposium on the Use of L-Dopa in Parkinsonism
Chicago Wesley Memorial Hospital, Chicago

October 23-24—University of Kentucky

Workshop on Cardiac Auscultation, Diagnosis and Therapy
University of Kentucky, College of Medicine, Lexington, Kentucky

October 25-29—American College of Chest Physicians

2nd Fall Scientific Assembly
Century Plaza Hotel, Los Angeles, California

October 28-31—American College of Surgeons, Committee on Trauma

10th Annual Course on Emergency Aid & Transportation
Chicago Fire Academy, Chicago

October 29-31—American College of Gastroenterology

Postgraduate Course
Statler Hilton, New York

October 29-November 2—Association of American Medical Colleges

81st Annual Meeting
Biltmore Hotel, Los Angeles, California

October 30-31—University of Florida

2nd Annual Birth Defects Symposium
University of Florida, College of Medicine, Gainesville, Florida

November 2-5—Medical Association of North America

November Assembly
Palmer House, Chicago

November 2-11—Mayo Clinic

Clinical Reviews
Mayo Civic Auditorium, Rochester, Minnesota

November 4—Forest Hospital

"Group Psychotherapy with Drug Abusers"
Forest Hospital, Des Plaines, Illinois

November 6-8—Congress of County Medical Societies

1970 Annual Meeting
Netherland Hilton Hotel, Cincinnati, Ohio

November 9-20—University of Illinois

Postgraduate Course in Laryngology & Bronchoesophagology
University of Illinois Hospital, Chicago

November 11-12—Cleveland Clinic Educational Foundation

Postgraduate Course in Gastroenterology
2020 East 93rd Street, Cleveland, Ohio

November 13—Kidney Foundation of Illinois

1970 Symposium on Glomerulonephritis
University of Chicago, Chicago

November 16-20—Chicago Medical Society

Postgraduate Course in Obstetrics & Gynecology
Knickerbocker Hotel, Chicago

November 9-13—Chicago Medical Society

Postgraduate Course in Internal Medicine
Knickerbocker Hotel, Chicago

November 6—Institute for Sex Education

12th Annual Teaching Conference on Sex Education
Sheraton-Chicago Hotel, Chicago

Nov. 6—Chicago Surgical Society

Scientific Program
University Club of Chicago, Chicago

Illinois Department of Mental Health—

Intensive Medical Review Courses began on August 8 and will continue until December 20, 1970. Subjects covered are Biochemistry, Physiology, Pharmacology, Microbiology and Pathology. Inquiries should be directed to the Department of Mental Health, 160 North LaSalle Street, Chicago 60601.

Illinois Academy of General Practice—

22nd Annual Postgraduate Program, for further information contact Academy of General Practice, 14 East Jackson Blvd., Chicago 60604.

\$3 Every Day for Taxes

Nearly \$3 a day in taxes is collected for every man, woman, and child in the United States. The Chamber of Commerce of the United States estimates that federal, state, and local taxes this year will amount to \$1,050 for every person in the country.

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MANUSCRIPT INFORMATION

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed.

Manuscripts should be typed, double spaced, and submitted in duplicate, one original and one carbon. An article should not exceed **12 to 16 manuscript pages**, (including illustrations) and should be briefer if possible. Please enclose personal glossy photos of author or authors. Snapshots are not suitable for reproduction.

References should be numbered and conform to the following style in the order given: name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for

the accuracy of references used with articles.

The first page should list the title, the name of the author (s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Make drawings and charts in black ink. If photographs are submitted, send black and white glossies. Number illustrations consecutively and indicate their place in the text. Number, indicate the top and place the author's name on the back of each illustration.

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DRIVERS ARE THE ULTIMATE CULPRITS

Interstate systems and highways are dangerously engineered. Automobiles are unsafe at any speed. Traffic cops are never around to nail that idiot who passed you at breakneck speed. If you have an accident, it's not your fault. Right?

Wrong.

Statistics collected and published in a booklet by The Travelers Insurance Companies keep drivers on the hook. Their compilation of accident facts makes it clear that 1969's record-breaking toll of 56,500 killed and 4,700,000 injured is attributable to driver error. If you are eager to find a scapegoat, don't read it.

Insurance companies have been berating drivers for a long time. Their essential motive is profit: if the accident rate is cut, claims will be cut and so will the cost of their product.

In their booklet, Travelers takes a poke at highway engineers and auto manufacturers, but they conclude from all the appalling statistics that drivers are the ultimate culprits.

Drive defensively—even if, or particularly if, the driver is young.

This advice, stated over the years, re-

mains sensible, according to the annual booklet of highway accident statistics.

One-fifth of the drivers in America today are less than 25 years of age. But they are involved in one-third of all fatal auto accidents.

Defensive driving, according to The Travelers booklet, is difficult because a driver is so often unable to identify irresponsible kids (or drinkers or seniles) in time to avoid them. The driver must assume that no one else is responsible and alert.

As in past years, excessive speed was the chief cause of deaths and injuries. High speed, however, is not necessarily the big killer. Driving too fast for conditions is lethal, too. Ten miles an hour can be too fast on glare ice or in a 'peasoup' fog.

Actually, the annual survey shows, more fatal accidents occur in clear, dry weather. Poor driving conditions make the driver more alert to what's ahead or around him. Only 1.8% of last year's automobile fatalities occurred in fog, and only 2.1% in snow.

The answer to the highway problem lies in more and better driver education, tighter laws and law enforcement.

SOCIO ECONOMIC *news*

A service of the Public Relations and Economics Division

By JOSEPH J. LOTHARIUS

Out-Patient Program Cuts Cost

Dilatation & Curettage was found to cost 80% less when performed on an out-patient basis during a year-long pilot program at Joliet's St. Joseph's Hospital. In addition, this D & C procedure, which is often accompanied by several days hospitalization, also frees badly needed hospital space. Dr. Leon Gardner, medical director of the 463-bed Joliet hospital, reported that patients also prefer the new program. Women are admitted about 8 a.m., taken to surgery, then to the recovery room and released about noon.

On the basis of the pilot program's success, the hospital is expanding its dollar-saving experiment into other procedures including: intraocular examination of infants and children under anesthesia; salivary and tear duct probing in infants and children; esophagoscopies and bronchoscopies; cystos and retrograde pyelography; minor orthopedic procedures; and excision of benign and malignant skin lesions.

Medicaid Payments In Four Days

A feasibility study will be conducted in Sangamon county to accelerate reimbursement of Medicaid payments to physicians, hospitals, pharmacists and dentists. The pilot program is scheduled to begin next January 1. Under the unique program, the provider of the services would file a voucher with a bank and be paid within four days. The bank would give the voucher information to a computer that has been programmed with all appropriate fee information. If the voucher request does not exceed the maximum fee allowed, it would be acknowledged and the provider credited with the money.

If successful, the plan will be expanded to include a seven county area and if that proves successful, the program would be tried on a statewide basis.

New Medicare Rules For Ambulance Services

A new reporting form for ambulance services under Medicare will eliminate some of the annoying letters sent to physicians by Medicare carriers. According to Continental Casualty Co., Part B Medicare carrier for much of the state, the new form should also expedite payments to physicians. It has been supplied to all appropriate ambulance services in the state. Continental also reported a change in

the guidelines for ambulance service, issued by the Social Security Administration. The new requirement calls for two-man crews on every ambulance. One of the crew members must have received training equivalent to the Standard & Advanced Red Cross Life Saving course.

Blue Shield In Florida Asked To Spell It Out

Florida physicians have asked Blue Shield in their state to print in bold type on every policy which does not pay usual and customary fees that "this policy does not necessarily cover the physician's entire fee." Delegates to the Florida Medical Association further have instructed Blue Shield "to work toward changes in the payment schedule to a percentage of usual and customary fees which would vary for each class or type of policy sold by Blue Shield and the latter should clearly inform each purchaser of the policy limitations." Would similar action by ISMS be the solution for like complaints voiced by Illinois physicians?



Improvement through education

BY MARY DUNHAM/CHICAGO

The rapid growth and changes being made in medicine are responsible for many proposals for change in our medical school's curricula. New courses are being offered in junior colleges now, that were not thought of years ago. The new courses offered in medical assisting are for training personnel who will perform tasks that will free the doctor and give him more of his valuable time.

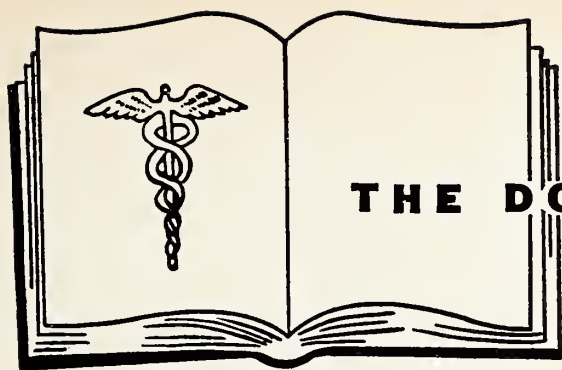
Members of the Illinois Medical Assistants Association who are nurses, medical secretaries, technicians, medical librarians and receptionists are dedicated to improvement through education. This is so that we may become more professional and better able to serve our doctor employers and their patients. During the year our members are injected with helpful hints through our bi-monthly newsletter. Our annual convention offers a three day symposium comprised of topics suited to the general at-

tendance. Usually several doctors lecture on different topics related to the field. The lectures are followed by open discussion and a question and answer period. From time to time there are panels of members who acquaint us with the responsibilities and the variety of duties they perform in their individual offices. A professional symposium is planned also for educational purposes.

We are constantly searching for doctors and other medical personnel who will lecture to us on topics that will help us elevate our standards as medical assistants.

If your medical assistant is interested in membership please contact Mrs. Norma Domanic, 150 Ash Street, New Lenox, Ill. 60451 or Mrs. Vivian Kraft, RR #2, Normal, Illinois 61761.

Mary Dunham
Chicago Chapter



THE DOCTOR'S LIBRARY

EXPERIENCE IN HEPATIC TRANSPLANTATION.
By Thomas E. Starzl, M.D., W. B. Saunders
Company, Philadelphia, 1969

It is unlikely that readers of the *Illinois Medical Journal* will be performing hepatic transplantation in the near future. Nevertheless, Illinois in general, and Chicago in particular, has had a long interest in the field of transplantation. In 1912, Alexis Carrel, then working in Chicago, accepted the Nobel Prize, saying, "From the technical point of view, the problem of organ transplantation has been solved." That Carrel was overstating the case regarding liver transplantation is clear from an inspection of Professor Starzl's book. His systematic approach to solution of technical problems of hepatic allografting is detailed in this unusual volume. Much of the book reads like a scientific mystery story in which the ultimate solution will never be revealed. As each chapter unfolds, new facts of anatomy, genetics and immunology are uncovered. Further clues of pharmacology, chemistry and microbiology lead the reader toward a better understanding of organ transplantation. He is left at the end wondering just how the story will turn out.

This is a marvelous book. It is particularly interesting to physicians who are keeping an eye on transplantation events. There is far more here than mere hepatic transplantation. There is a history of clinical transplantation over the last five years, early results of kidney transplantation using Azathioprine and Prednisone, and the story of development of antilymphocyte globulin and its early use in man.

Five years ago, Tom Starzl's book entitled, *EXPERIENCE IN RENAL TRANSPLANTATION* appeared. This presented the first large series of successful renal transplants, and recently that book has been referred to as the "Transplantation Bible." It showed

that with drug treatment alone, real possibilities existed for successful renal transplantation. The present volume is a companion to that work. It was prepared with the help of a Northwestern University medical student, Charles W. Putnam, who then moved his research activities to the University of Colorado School of Medicine where he currently serves as an intern.

Illinois, Chicago and Northwestern's particular stake in this volume is well known to those who followed Tom Starzl's career. He holds Ph.D. and M.D. degrees from Northwestern University. He performed his early experimental liver transplantations in the surgical research laboratories on East Chicago Avenue. This book begins there and pays tribute to his early research associates. It ends with a list of 25 human liver transplants performed at the University of Colorado from March, 1963, through February, 1969. As it details the care of these patients, this book teaches the lessons of current immunosuppression in man, records experience in managing infectious complications occurring in the immune suppressed individual, covers current theory regarding histocompatibility typing, as well as other important subjects such as anesthesia and intra-operative care of transplant patients. Liver transplantation has far reaching effects and as these cause changes in the coagulation mechanism, for example, separate chapters are contributed by authorities in these subjects.

This is a classic volume. It is well printed and magnificently illustrated with drawings by Jean McConnell of the Northwestern University Medical Art Department. It will be a valuable addition to the growing shelf of modern transplantation texts which are telling the story of surgery's newest field of endeavor.

John J. Bergan, M.D.

NEW
PHARMACEUTICAL
SPECIALTIES
 by Paul deHaen

For detailed information regarding indications, dosage, contraindications, and adverse reactions, refer to the manufacturer's package insert or brochure.

Single Chemicals: Drugs not previously known, including new salts.
Duplicate Single Products: Drugs marketed by more than one manufacturer.
Combination Products: Drugs consisting of two or more active ingredients.
New Dosage Forms: Of a previously introduced product.

The following new drugs have been marketed:

NEW SINGLE CHEMICAL

CLEOCIN HCl Antibiotic R
Manufacturer: Upjohn
Nonproprietary Name: Clindamycin
Indications: Infections caused by gram-positive organisms which are susceptible to its action.
Contraindications: Hypersensitivity to the compound.
Dosage: Adults Mild to moderately severe infections—150-300 mg./6 hrs. Severe infections—300-450 mg./6 hrs.
 Children: Mild to moderately severe infections—8-16 mg./kg./day, t.i.d. or q.i.d. Severe infections—16-20 mg./kg./day, t.i.d. or q.i.d.
Supplied: Capsules, 75 and 150 mg.
 Sensitivity disks, 2 mcg.

GEOPEN Antiinfectives-Penicillin & Derivatives R
Manufacturer: Roerig Div., Pfizer

PYOPEN Antiinfectives-Penicillin & Derivatives R
Manufacturer: Beecham Pharmaceuticals
Nonproprietary Name: Carbenicillin disodium
Indications: Infections due to susceptible *Pseudomonas aeruginosa*, *Proteus* species and certain strains of *E. coli*.
Contraindications: Known penicillin allergy
Dosage: i.m., i.v., individualized
Supplied: Vials, 1 and 5 gm.

KAFOCIN Antibacterials-Urinary R
Manufacturer: Lilly
Nonproprietary Name: Cephaloglycin (as the dihydrate)
Indications: Acute and chronic infections of the urinary tract due to susceptible strains of *E. coli*, *Klebsiella-Aerobacter*, staphylococci, certain of the *Proteus* species and enterococci.
Contraindications: Known allergy to cephalosporin antibiotics
Dosage: Usual adult dose: 250 mg. q.i.d. 10 days. Severe infections: 500 mg. q.i.d.
 Usual children's dose: 25-50 mg./kg.
Supplied: Pulvules, 250 mg.

SECRETIN-BOOTS Diagnostics-Organ Function R
Manufacturer: Boots, England

Distributor: Warren-Teed
Active ingredient: Secretin (Obtained from porcine duodenal mucosa.)
Indications: Diagnosis of pancreatic disorders
Contraindications: History of atopic asthma, allergy or positive skin test.
Dosage: For dosage and administration see package insert.
Supplied: Rubber-capped vials, 10 cc sterile powder.

SERENTIL Ataraxic R
Manufacturer: Sandoz
Nonproprietary Name: Mesoridazine
Indications: Schizophrenia, behavioral problems in mental deficiency and chronic brain syndrome, alcoholism—acute and chronic, and psychoneurotic manifestations.
Contraindications: Severe central nervous system depression or comatose states from any cause. Hypersensitivity to the drug.
Dosage: Dependent on conditions treated.
Supplied: Tablets, 10, 25, 50 and 100 mg.
 Ampuls, each cc contains 25 mg. (as the besylate)

DUPLICATE SINGLE PRODUCT

DIPHENHYDRAMINE
HYDROCHLORIDE Antihistamine R
Manufacturer: Wyeth
Nonproprietary Name: Diphenhydramine HCl
Indications: Symptomatic relief of hay fever and other allergic entities. Prevention and control of blood transfusion reactions of the non-hemolytic, non-pyrogenic type. Prophylactic treatment of symptoms of mild bronchial asthma. Antiemetic action.
Contraindications: Intra-arterial injection
Dosage: Usually effective orally. In emergencies i.m. or i.v. administration may be more effective. Adults: 10-50 mg. i.v. or by deep i.m. injection 100 mg. if required Maximum daily dosage, 400 mg. Children: i.m. route—10-30 mg. by deep i.m. injection. i.v. route—5 mg./kg./24 hr. in three divided doses.
Supplied: Tubex unit dose in prefilled sterile cartridge-needle units, each cc contains 50 mg.

ESTRAVAL P.A.* Estrogens R
 (*Prolonged Action)
Manufacturer: Tutag
Nonproprietary Name: Estradiol valerate
Indications: Disturbances of the menstrual cycle, dysfunctional uterine bleeding, amenorrhea, deficiency syndromes, postpartum breast engorgement and advanced mammary carcinoma in women 5 or more years post-menopausal. Often induces regressive changes and exerts a palliative action in carcinoma of the prostate.
Contraindications: History of known or suspected malignancy of the uterus or breast.
Dosage: i.m., individualized.
Supplied: Multidose vials, 10 cc.

E-IONATE-P.A.* Estrogen R
 (*Prolonged Action)
Manufacturer: Tutag
Nonproprietary Name: Estradiol Cypionate
Indications: Symptoms of menopause, natural or induced, treatment of pruritis vulvae and senile vaginitis.
Contraindications: Pre-cancerous lesions of the breast or genital tract or a familial history of these types of carcinoma.
Dosage: i.m. only, 1-5 mg./week initially. Main-

tenance 2-5 mg. every three or four weeks.
Supplied: Vials

T-IONATE P.A.* Androgen R
(*Prolonged Action)
Manufacturer: Tutag
Nonproprietary Name: Testosterone Cypionate
Indications: Male: Replacement therapy in conditions associated with deficiencies or absence of endogenous testicular hormone.
Female: Control of post-partum lactation. Palliative effect in inoperable cancer.
Male and Female: Anabolic effect in conditions associated with androgen deficiency.
Contraindications: Prostatic carcinoma, severe hypercalcemia and severe cardiorenal disease. Pregnancy.
Dosage: Individualized.
How supplied: Vials, 10 cc

TESTOSTROVAL P.A.* Androgen R
(*Prolonged Action)
Manufacturer: Tutag
Nonproprietary Name: Testosterone enanthate
Indications: Androgenic deficiency states
Contraindications: Prostatic or breast cancer in the male and in elderly patients where overstimulation is to be avoided.
Dosage: i.m., individualized
Supplied: Multi-dose vials, 5 cc

IRATES GRANUCAPS Vasodilator-Coronary R
Manufacturer: Tutag
Nonproprietary Name: Nitroglycerin
Indications: Angina pectoris associated with or resulting from coronary insufficiency, coronary artery disease, coronary occlusion or myocardial infarctions.
Contraindications: Idiosyncrasy to nitroglycerin, early myocardial infarction, glaucoma, increased intracranial pressure and severe anemia.
Dosage: One capsule at 12 hour intervals (before breakfast and at bedtime). Dose may be increased to one every 8 hrs., or as directed.
Supplied: Capsules, 2.5 mg.

COMBINATION PRODUCT

CAMALOX G.I. Prep.-Antacids o-t-c
Manufacturer: Rorer
Composition: Balanced suspension of
Magnesium hydroxide
Aluminum hydroxide
Calcium carbonate
Indications: Treatment and management of peptic ulcer, gastritis, gastric hyperacidity, hiatal hernia, peptic esophagitis, heartburn, indigestion and upset stomach.
Contraindications: Severe debilitation or kidney failure.
Dosage: 2-4 tsp. 1/2 to 1 hr. after meals and at bedtime.
Supplied: Liquid suspension, 16 oz. bottle

FERROBID Hematinic/Vitamin
Combination o-t-c
Manufacturer: Meyer
Composition: Ferrous Fumarate 225 mg.
(75 mg. elemental iron)
Copper sulfate 8 mg.
Ascorbic Acid 100 mg.
Indications: Optimal iron absorption with minimal gastric irritation.
Contraindications: None mentioned
Dosage: Usual daily dose—one capsule twice a day.
Supplied: Timed action Duracap Capsules

FLU-IMUNE Biological R
Manufacturer: Lederle
Composition: Each cc contains
A₂/Aichi/2/68 (Hong Kong Variant) 400 CCA units
B/Mass/3/66 300 CCA units
Indications: Influenza virus vaccine-bivalent
Contraindications: Hypersensitivity to eggs or egg products.
Dosage: Adults: 1.0 cc s.c., followed by a second dose of 1.0 cc s.c. in 6-8 weeks.
Children: 3 mos.-5 yrs.—0.1-0.2 cc s.c., followed by a second dose in two weeks. A third dose of 0.1-0.2 cc s.c. should be administered about 2 mos. later.
Children 6 to 10 yrs.: 0.5 cc s.c., repeated in 6-8 weeks.
Supplied: Vials, 10 cc

LAROBEC Vitamin/Mineral Comb. R
Manufacturer: Roche
Composition: Thiamine mononitrate 15 mg.
Riboflavin 15 mg.
Niacinamide 100 mg.
Calcium pantothenate 20 mg.
Cyanocobalamin 5 mcg.
Folic acid 0.5 mg.
Ascorbic acid 500 mg.
Indications: Nutritional supplementation for levodopa therapy.
Contraindications: None mentioned
Dosage: One or two tablets daily.
Supplied: Tablets

SWIM-EAR Ear Preparations o-t-c
Manufacturer: Savage
Composition: Boric acid 2.75%
Isopropyl Alcohol 97.25%
Indications: Prevention of swimmer's ear (external otitis).
Contraindications: None mentioned
Dosage: 3-6 drops in each ear after swimming or showering
Supplied: Plastic squeeze bottles with otic tip, 1 oz.

T-E IONATE-P.A.* Androgen/Estrogen R
Combination
(*Prolonged Action)
Manufacturer: Tutag
Composition: Each cc contains:
Testosterone Cypionate 50 mg.
Estradiol Cypionate 2 mg.
Indications: Menopausal symptoms, male climacterium and osteoporosis.
Contraindications: High familial incidence of cancer including neoplasms or pre-cancerous lesions in the mammary, genital or prostatic areas.
Dosage: Usual dose: 1 cc at four week intervals.
Supplied: Vials

NEW DOSAGE FORM

CHOLEDYL ELIXIR Bronchodilator R
Manufacturer: Warner-Chilcott
Nonproprietary Name: Oxtriphylline
Indications: Relief of bronchospasms in chronic obstructive lung disease.
Contraindications: None mentioned
Dosage: Adult: 2 tsp. q.i.d.
Supplied: Elixir, each tsp. contains 100 mg.
EFUDEX Cancer Chemotherapy R
Manufacturer: Roche
Nonproprietary Name: Fluorouracil
Indications: Multiple actinic or solar keratoses
Contraindications: Hypersensitivity to any of its components

(Continued on page 465)

Missed Myocardial Infarction

Myocardial infarctions have a language that sometimes is not heard by medical audiences, according to Walter Schweizer, M.D., who terms the incidence of missed myocardial infarction "astounding."

Dr. Schweizer made the observation in "Missed Myocardial Infarction," an article in an issue of *diagnostica*, an international medical journal produced by Ames Company, Division Miles Laboratories, Inc. *diagnostica* is published in six languages and distributed to physicians in 112 countries.

Dr. Schweizer is Head of the Department of Cardiology in the University Clinic of Internal Medicine, Burgerspital, and Professor of Cardiology in the Faculty of Medicine of the University of Basel, Switzerland.

Twenty per cent of all myocardial infarctions are not diagnosed, Dr. Schweizer said. Half of these undiagnosed infarctions occur when sudden death or death within a few minutes is the first and only manifestation of the myocardial infarction.

The other half occur when the language of the infarction is not heard or is interpreted incorrectly by medical audiences. Dr. Schweizer listed several reasons:

"When the myocardial infarction is painless (no chest pain or pain equivalent experienced) the infarction is 'silent' and remains undetected unless fortuitously discovered during electrocardiography performed for other reasons." There is no firm basis for suspicion of infarction.

"When the infarction causes only limited pain; mild angina on effort of mild, brief midchest pressure. Symptoms may be so slight that the patient does not heed them and does not bother to consult a physician." This infarction is not silent but it speaks very softly.

"When the myocardial infarction does not produce adequately specific alterations" there may be an ambiguous clinical picture even if the patient consults a physician and

a careful examination is performed. Here the infarction is painful but it lacks typical signals. It is not silent but it speaks unintelligibly.

"When the investigation to demonstrate the infarction is begun too late there is again an ambiguous clinical picture because the infarction is observed after the signs have subsided. The infarction does not remain silent: it "speaks loudly and unmistakably but only at a time when no one is within hearing range."

Today it is vital that myocardial infarction and the underlying coronary heart disease should not be missed for three reasons, Dr. Schweizer said:

1. "Intensive and aggressive coronary care has reduced hospital mortality due to myocardial infarction by approximately 50%" Faster transportation and efficient first aid also figure here.

2. "Anticoagulants improve the chance of survival after the initial myocardial infarction." Recent studies have shown that the two-year mortality rate can be cut approximately in half.

3. "Sudden death occurs in cigarette smokers five times as frequently as in nonsmokers."

When myocardial infarction first manifests itself in sudden death or when it is truly silent the medical profession is helpless, Dr. Schweizer said. But in the other cases medicine is not helpless. He recommends two ways in which medicine can improve its approach to this medical problem:

1. "Informing the public concerning the symptoms that may possibly indicate myocardial infarction, reasonable measures to take when these symptoms occur and the urgency of such measures."

2. "Improving communication with medical students and fellow physicians regarding diagnosis of myocardial infarction."

Clinics for Crippled Children Scheduled

Twenty-five clinics for Illinois' physically handicapped children have been scheduled for November by the University of Illinois, Division of Services for Crippled Children. The Division will conduct twenty-one general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing service. There will be three special clinics for children with cardiac conditions and rheumatic fever, and one for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- Nov. 3—Belleville—St. Elizabeth's Hospital
- Nov. 3—Fairfield—Fairfield Memorial Hospital
- Nov. 3—Pittsfield—Illini Community Hospital
- Nov. 4—Hinsdale—Hinsdale Sanitarium
- Nov. 5—Sterling—Community General Hospital
- Nov. 5—Effingham—St. Anthony Memorial Hospital
- Nov. 5—West Frankfort—UMWA Union Hospital
- Nov. 6—Chicago Heights Cardiac—St. James Hospital
- Nov. 10—Peoria—St. Francis Children's Hospital
- Nov. 10—East St. Louis—Christian Welfare Hospital
- Nov. 11—Champaign-Urbana — McKinley Hospital
- Nov. 11—Joliet—St. Joseph's Hospital
- Nov. 12—Springfield General—St. John's Hospital

- Nov. 12—Macomb — McDonough District Hospital
- Nov. 17—Rock Island Area General—Moline Public Hospital
- Nov. 18—Rockford—St. Anthony Hospital
- Nov. 18—Centralia—St. Mary's Hospital
- Nov. 18—Evergreen Park—Little Company of Mary Hospital
- Nov. 18—Springfield Pediatric Neurology—Diocesan Center
- Nov. 19—Decatur—Decatur Memorial Hospital
- Nov. 19—Elmhurst Cardiac — Memorial Hospital of DuPage County
- Nov. 20—Chicago Heights Cardiac—St. James Hospital
- Nov. 24—Peoria—St. Francis Children's Hospital
- Nov. 24—East St. Louis—Christian Welfare Hospital
- Nov. 25—Elgin—Sherman Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

Publisher Attacks Union Power

"Inability of management to control labor's insatiable demands is a root cause of the inflationary spiral we are trapped in today, and it is time the government recognized it. It is axiomatic that higher wages cause higher prices. It is likewise clear that as a consequence of overly protective labor laws, the pendulum has swung too far to the side of unionism.

"For these and other reasons, I am now calling on our governments to initiate total re-examination of this nation's labor laws at both the federal and state levels, and to revise and enact the legislation necessary to correct this imbalance between management and labor."—William F. Schmick, Jr., president, American Newspaper Publishers Association and publisher, Baltimore Sun, in speech to newspapers' convention.

Cellular Changes After Hemorrhagic Shock Can Cause Fatal Lung Damage

A soldier wounded in the leg by a mortar shell is treated and seems to be recovering from the initial shock and other effects of his injury. His blood pressure returns to normal and his condition appears stabilized. But he dies three or four days later of respiratory failure.

Why?

According to Dr. James W. Wilson and associates, Duke University Medical Center, death in such a case could be the result of a cellular chain reaction set up in the lungs as a secondary response to hemorrhagic shock. Thousands of victims of automobile and other accidents die each year from the initial effects of shock, and this previously unsuspected chain reaction may account for many additional fatalities.

Dr. Wilson described this sequence of events as seen in experimental animals at the Third Symposium of the International Inflammation Club at Brook Lodge, Kalamazoo, Michigan.

He identified it as part of the inflammatory process by which the body responds to injury, and reported the effective but still experimental treatment of this pulmonary reaction in shock-induced animals with massive single injections of a steroid drug, methylprednisolone sodium succinate (**Solu-Medrol**, Upjohn). This experimental treatment has not yet been clinically tested in humans nor has it been approved for such use. The steroid drugs, he said, partially prevented or slowed the chain reaction which starts with vascular permeability and the sticking or adherence of white blood cells to arteries and capillaries in the lungs.

Although this adherence of cells to vessel walls is one of the characteristics of the inflammatory response, Dr. Wilson said, "Certain aspects of the leukocyte stickiness in the pulmonary vessels in hemorrhagic shock are different from the leukocyte stick-

iness of the classic inflammatory reaction."

He pointed out that in dogs subjected to hemorrhagic shock, these differences included failure of the leukocytes to emigrate from the vessel or to form the pseudopod essential to that action; they adhered more closely to the walls and differed in form and cellular content from those usually seen in inflamed tissue.

"Leukocyte sequestration and fragmentation in the lungs of animals subjected to endotoxin or septic shock is a well-known phenomenon," Dr. Wilson said. "What relation endotoxins or sepsis plays in the pathogenesis of the pulmonary injury of hemorrhagic shock is not known."

He reported that respiratory failure has been documented as a significant cause of death in soldiers in Vietnam who have suffered non-thoracic trauma. "Changes in the lungs of those soldiers are very similar to the changes observed in the experimental animal subjected to hemorrhagic shock," the investigator commented.

Similar changes also have been noted in lung biopsies from human patients after being placed on cardiopulmonary by-pass, he said.

These alterations in hemodynamic homeostasis, with increased vascular permeability and leukocyte stickiness resembling cellular events of the inflammatory reaction, responded well to Solu-Medrol before and after induction of hemorrhagic shock in experimental animals, Dr. Wilson reported.

"Preliminary results are that most of the morphologic alterations at both the light and electron microscopic level are prevented," he said. "The lung is congested after reinfusion of the shed blood, but there is no hemorrhage or extensive edema and the sequestration of leukocytes is reduced."

As If You Didn't Know

Your child can cost as much as \$25,000 to raise, depending on where you live. Costs for raising children to age 18 range from \$19,360 in a rural, nonfarm area of the North Central states, to \$25,000 for similar areas in the West. The figures, released by the Agriculture Department, also indicate that it costs 45% more to provide for an 18-year old than for a one-year old.

Drip Infusion Urography Called Effective In Patients With Poor Renal Function

Satisfactory and safe visualization of the urinary tract has been obtained by drip infusion urography with relatively high doses of the contrast agent Hypaque in 174 patients with reduced renal function, according to a report in the *Journal of Urology* (103:267, 1970).

"The present observations confirm the fact that drip infusion urography can be used successfully to visualize renal and proximal ureteral size when renal function is severely reduced," state Drs. R. Dale Ensor, E. Everett Anderson and Roscoe E. Robinson of Duke University Medical Center.

Emphasizing the safety of the procedure, the investigators say that "evidence suggests that the procedure exerted no adverse effect on renal function.

"A comparison of this technique with that for double-dose urography demonstrated the greater diagnostic usefulness of this procedure, especially in patients with severe renal failure."

A 50% solution of Hypaque (sodium diatrizoate—Winthrop Laboratories) diluted with five percent dextrose in water was rapidly infused intravenously in the 174 patients, all of whom had some form of renal disease. X-ray films were made two minutes after the infusion was started, and two minutes and 10 minutes after completion.

Regarding diagnostic quality, the Duke University team reports 48% of the urograms provided excellent or satisfactory visualization of major calyces, renal pelves and both ureters. An additional 21% of the urograms adequately visualized kidney size and both proximal ureters. Twenty-one percent of the urograms "were comparable in quality to that obtained with a good retrograde pyelogram," the authors note. Of considerable significance, they add, is that 53% of the urograms were satisfactory in patients whose plasma creatinine clearance ranged between five and ten ml. per minute.

The few adverse reactions resulting from the procedure—such as nausea, retching and cutaneous flushing—were mild and of brief duration. One patient experienced mild and transient pulmonary edema with recumbent dyspnea.

"The present findings also suggest that even larger intravenous doses of sodium diatrizoate do not exert an acutely adverse influence on renal function per se in azotemic patients with severe renal disease," the report states.

While urging further investigation of drip infusion urography, the authors conclude that the procedure was "tolerated extremely well by all patients."

Routine Urine Tests

In the absence of an agreed policy on screening for disease, the responsibility lies with general practitioner, public-health department and hospitals. In a two-year period, about 1000 patients have responded to a tape-recorded request, played at intervals in the waiting-room, or to postal or health visitor follow-up if they had not visited the surgery. Thirty-three cases of glycosuria, 20 of albuminuria, and 26 of hematuria were detected, and 42 patients are benefiting from treatment given as a result of screening. Among the major lesions picked up were diabetes (15), carcinoma of the bladder (1), papilloma of the bladder (2), and renal stone (1). The screening program was amply justified by the results: It thus seems unfortunate that the Department of Health and Social Security supplies other sections of the Health Service with the tool for screening but refuses to provide diagnostic strips free of charge to general practitioners. (Murdo Macleod.: *Routine Urine Tests in General Practice*. *The Lancet* [May 30] 1970, page 1167.)

Guide to Evaluation of Permanent Impairment Of Skin Available

The twelfth guide in the series, "Guides to the Evaluation of Permanent Impairment," developed by the Committee on Rating of Mental and Physical Impairment of the AMA, is now available.

The guide entitled "The Skin," like all the others in the series, has been designed primarily for use by physicians. However, it would be of interest and use to all concerned with the medical, administrative or judicial aspects of programs for the disabled. Previously published guides dealt with the extremities and back; the digestive system; and the other vital systems.

The guide is available without charge upon written request to the Committee on Rating of Mental and Physical Impairment, 535 North Dearborn Street, Chicago, Ill. 60610.

Wet Weather Steer for Drivers: Accidents Rise on Rainy Days

When rain reduces visibility, highway accidents and fatalities mount, especially after sundown. Streaky windshields, pounding rain and headlight glare make it hard for drivers to see, and wet roads make it hard for them to stop. When pavements are slick with water and road film caused by oil, grease and dust, a car going 30 miles an hour needs 147 feet to stop, as against 88 when the road is dry. At faster speeds "tire hydroplaning" can result—with wheels supported by water alone, like a skier crossing a lake. When you drive in wet weather, observe these safety measures:

Slow down. On rainy days, play safe. Reduce speed at least 20 per cent and increase your braking interval.

Turn on your lights, so other drivers and pedestrians can see you, no matter how hard the rain falls.

Beware of puddles. Splashing through a deep one can flood your motor, weaken your brakes, or both. If fording is your only choice, take it slowly; be sure to check your brakes when you reach dry ground.

Watch surface conditions. Even after rain stops, roads can remain slippery for several hours. Side streets can be especially hazardous.

Don't wait until it rains to check your windshield wipers and washers. Keep the defroster in repair. And always carry a rag for wiping the glass inside and out.

Where Most Accidents Occur

Of 115,000 accidental deaths during 1968, 14,300 were job related, about half as many as the 28,500 caused in the home. Biggest killer: Motor vehicles, 55,200.

56,500 lives were lost on America's highways in 1969, according to an annual report from The Travelers Insurance Companies. In addition, more than 4,700,000 men, women and children were injured.

Accident Pamphlet

"Place a child's toys, clothes and food within his reach, so he does not have to climb on furniture to get them," advises a CNA/insurance executive in a new pamphlet, *Preventing Children's Accidents*, which cautions that falls, most of them in the home, kill hundreds of children every year.

The booklet provides parents with 15 pages of practical suggestions gathered during a study of insurance files. It covers such areas as boating, camping, sports, bicycles, autos, and safety in the home.

To obtain copies of *Preventing Children's Accidents*, write: Children's Accidents, Booklet Dept., National Research Bureau, 424 N. Third St., Burlington, Iowa 52601. Copies are 25 cents each; quantity prices available on request.

Food for Thought

In May, 1919, at Dusseldorf, Germany, the Allied Forces obtained a copy of the "Communist Rules for Revolution." Fifty-one years later these guidelines are still being followed. As you read the following consider the world today. Maybe it's just a coincidence. . . .

A. Corrupt the young; get them away from religion. Get them interested in sex. Make them superficial; destroy their ruggedness.

B. Get control of all means of publicity, thereby:

1. Get people's minds off their government by focusing their attention on athletics, sexy books and plays and other trivialities.
2. Divide the people into hostile groups by constantly harping on controversial matters of no importance.
3. Destroy the people's faith in their nation's leaders by holding them up to contempt, ridicule and disgrace.

4. Always preach true democracy, but seize power as fast and ruthlessly as possible.

5. By encouraging government extravagance, destroy its credit, produce fear of inflation with rising prices and general discontent.

6. Incite unnecessary strikes in vital industries, encourage civil disorders and foster a lenient and soft attitude on the part of government toward such disorders.

7. By specious argument cause the breakdown of the old moral virtues, honesty, sobriety, self restraint, faith in the pledged word, ruggedness.

C. Cause the registration of all firearms on some pretext, with a view to confiscating them and leaving the population helpless.

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Obituaries

***Max Bernauer**, Chicago, died April 30 at the age of 77.

Norman V. DeNosaquo, Chicago, died June 26 at the age of 66. He was director of the Drug Utilization Section of the Department of Drugs of the AMA.

***Hobart William Edson**, Rockford, died December 16 at the age of 74. He was a member of the ISMS Fifty-Year Club.

***Alonzo T. Griffin**, Chicago, died April 22 at the age of 87. He was a member of the ISMS Fifty-Year Club.

***Richard D. Kearney**, Chicago, died August 12 at the age of 66.

***Allan B. King**, Chicago, died August 21 at the age of 75. He was chief medical examiner for the Prudential Insurance Co., and a member of the ISMS Fifty-Year Club.

***Leonard A. Kratz**, McHenry, died February 19 at the age of 68.

***Harold Linn**, Chicago, died August 24 at the age of 34. He was an instructor at the Chicago Medical School.

***John W. Long**, Robinson, died April 23 at the age of 79. He was a member of the ISMS Fifty-Year Club, and served as secretary of the Crawford County Medical Society for over 40 years.

***Lawrence S. Mann**, Skokie, died August 8 at the age of 53. He was former co-chairman of the Mt. Sinai Hospital Department of Surgery.

***Roger W. Poborsky**, Riverside, died August 28 at the age of 70. He was a clinical professor of surgery at the Chicago Medical School.

***Fred E. Scheppler**, Somonauk, died January 14 at the age of 79. He was past president of the DeKalb County Medical Society, and a member of the ISMS Fifty-Year Club.

***John R. Sharp**, Springfield, died August 10 at the age of 61. He was very active in various philanthropic organizations in and around Springfield.

***J. Lewis Vertuno**, Melrose Park, died January 9 at the age of 51.

***Maude H. Winnett**, Chicago, died April 10 at the age of 85. She was a member of the ISMS Fifty-Year Club.

**Indicates member of Illinois State Medical Society*

STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION (Act of October 23, 1962: Section 4369, Title 39, United States Code)

1. Date of Filing: September 30, 1970.

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7. Owner (If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual must be given.) None.

8. Known bondholders, mortgagees, and other security holders owning or holding 1 per cent or more of total amount of bonds, mortgages or other securities (If there are none, so state): None.

9. For completion by nonprofit organizations authorized to mail at special rates (Section 132.122, Postal Manual). The purpose, function, and nonprofit status of this organization and the exempt status for Federal income tax purposes have not changed during preceding 12 months.

10. Extent and Nature of circulation.

	Average no. copies each issue during preceding 12 months	Actual number of copies of single issue published nearest to filing date
A. Total no. copies printed (Net Press Run)	12,500	12,500 (Sept. '70)
B. Paid circulation		
1. Sales through dealers and carriers, street vendors and counter sales	None	None
2. Mail subscriptions	11,024	11,254
C. Total paid circulation	11,024	11,254
D. Free distribution (including samples by mail, carrier or other means)	679	593
E. Total distribution (Sum of C and D)	11,703	11,847
F. Office use, left-over, unaccounted, spoiled after printing	797	653
G. TOTAL (Sum of E & F— should equal net press run shown in A)	12,500	12,500

I certify that the statements made by me above are correct and complete. (Signature of editor, publisher, business manager, or owner)

John A. Kinney, Business Manager

New Pharmaceuticals

(Continued from page 457)

Dosage: Apply twice daily with sufficient cream or solution to cover lesion. Continue medication until inflammatory reaction reaches the erosion, necrosis and ulceration stage. Usual duration—2-4 weeks.

Supplied: Solution, 10 cc drop dispensers, 2% or 5% weight/weight

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LarodopaTM—the Roche brand of levodopa—is now available for general prescription use throughout the United States. Patients suffering from Parkinson's Disease and Syndrome, regardless of where they live, will be able to receive the benefits of this new therapeutic agent. Approximately one million patients in the United States are believed to be suffering from Parkinson's with 50,000 new victims diagnosed each year.

Larodopa (levodopa) is available in both tablets and capsules, in two strengths: 0.5 Gm and 0.25 Gm.

The 0.5 Gm tablets are pink, capsule-shaped, biconvex, and scored; they are imprinted "Roche-56."

The 0.25 Gm tablets are pink, round, flat, bevel-edged and scored; they are imprinted "Roche-57."

The 0.5 Gm capsules are pink, hard-shell, two piece capsules, imprinted "Roche-54."

The 0.25 Gm capsules are two piece, hard-shell capsules, imprinted "Roche-55." The capsule body is beige and the cap is pink.

For detailed information on dosage, administration, precautions, side effects, and contraindications, the attached package insert should be consulted.

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SPECIALTY REVIEW COURSE IN MEDICINE, PART II, Nov. 16
SPECIALTY REVIEW COURSE IN ORTHOPEDICS, Nov. 16 & Dec. 7
AMPUTATION SURGERY & REHABILITATION, 2½ Days, Oct. 22
SURGERY OF COLON & RECTUM, One Week, October 26
BLOOD VESSEL SURGERY, One Week, November 2
BASIC OBSTETRICS, One Week, November 16
BASIC GYNECOLOGY, One Week, November 30
SURGICAL & RADIATION THERAPY OF GYNE. MALIGNANCIES, Nov. 30
VAGINAL APPROACH TO PELVIC SURGERY, One Week, December 14
UROLOGY FOR GENERAL PRACTITIONERS, Two Days, Nov. 19
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Information concerning numerous other continuation courses available upon request.

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Family Practice exam slated

The American Board of Family Practice announces that it will give its second examination for certification in various centers throughout the United States. The examination will be over a two-day period on February 27-28, 1971.

Information regarding the examination and eligibility can be obtained by writing: Nicholas J. Pisacano, M.D., secretary-treasurer, American Board of Family Practice, Inc., University of Kentucky Medical Center, Annex #2, Room 229, Lexington, Kentucky 40506.

The deadline for receiving completed applications is November 1, 1970.

Why E. Coli Attack Kidney Under Study

The problem of why certain bacteria attack only specific organs is being studied by a University of Chicago scientist.

Dr. Floyd A. Fried, assistant professor of surgery in the University's Division of Biological Sciences and The Pritzker School of Medicine, is working with A. Philip De Pauw and Michael Ginsburg, students in the Pritzker School, examining the mechanisms in which a particular bacteria, *E. coli*, attack and injure the kidney.

"About 75% of all infections of the urinary tract can be attributed to *E. coli*," Dr. Fried stated.

Certain *E. coli* can attack and destroy the membrane that surrounds red blood cells. Dr. Fried's research, supported by the U.S. Public Health Service, indicates that these same types also attack and destroy the membrane surrounding an intracellular enzyme storing structure, the lysosome.

Destruction of this lysosomal membrane releases enzymes, used to break down proteins and other complex molecules to simpler forms that can be used to supply cell energy. These liberated enzymes may then attack and destroy the cell. The dead cell then provides a breeding place for more bacteria, and the process escalates into a kidney infection known as pyelonephritis.

E. coli normally reside in the intestine. They may enter the urinary tract through the bloodstream and lymphatic system or may directly ascend through the urinary tract itself.

Editor Theodore R. Van Dellen, M.D.
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BLUE SHIELD REPORT



FOR *Illinois Physicians*

Blue Shield Offers Alcohol Program

Blue Shield has developed a new program to combat alcoholism which includes a one-hour, two-part film produced for television, a half-hour radio program and a 40 page full-color booklet.

The film, entitled "The Other Guy," is a drama-documentary based on the life of a young business executive.

It stars Ben Piazza who relives situations that lead to his becoming an alcoholic. The film includes brief interviews with recovered alcoholics and authorities on alcoholism. Among those interviewed are Senator Harold Hughes, chairman of the Senate Subcommittee On Alcoholism and Narcotics, and Dr. Roger Egeberg of the Department of Health, Education and Welfare.

The half-hour radio programs feature interviews with alcoholism authorities and actual alcoholics.

The film, programs and booklets, produced by the National Association of Blue Shield Plans, will be

made available after January 1, 1971, by the Blue Shield Plan of Illinois Medical Service. For additional information contact:

Public Affairs Department
Illinois Blue Shield
222 North Dearborn Street
Chicago, Illinois 60601
Phone: 312-661-3071

British Private Health Insurance Grows

Blue Shield's new affiliate in England has announced that 60,000 more Britains elected to be protected by their private health care coverage during 1969. The British United Provident Association (BUPA) reported that as of December 31, 1969, it had 701,000 subscribers, representing more than 1.5 million members. BUPA pays for covered health care services, on a private basis, to individuals and groups who seek an alternative to the British National Health System.

Takes Over in November, '71

NEW NABSP PRESIDENT NAMED

Ned F. Parish, Executive Vice President of the National Association of Blue Shield Plans (NABSP), has been designated to become president when John W. Castellucci retires next year.

In an announcement released from Chicago headquarters, Ira C. Layton, M.D., of Kansas City, Missouri, chairman of the National Association of Blue Shield Plans, said:

"By designating Mr. Parish at this time as the one who will succeed Mr. Castellucci as president when he retires on November 1, 1971, we will assure the association of continuity in our top management."

Castellucci, who recommended the need for a plan of succession, said:

"We are facing many critical issues in health care financing. It is essential that we have a strong and consistent approach to meeting them, and Ned Parish will be able to provide the needed administrative leadership."

Parish, an outstanding administrator in the health care prepayment field for more than a quarter of a century, has been executive vice president of the association since 1967.

He began his prepayment career in 1939 in Cleveland. In 1947, he played a key role in the establishment of the Arizona Blue Shield Plan and was named assistant director of Arizona Blue Shield and Blue Cross in 1949.

Parish was named assistant director of the Blue Shield Plans, the forerunner of the National Association of Blue Shield Plans, in 1953.

Castellucci has been chief executive officer of NABSP since 1955. At that time the association had 7 employees, and Blue Shield Plans covered 34 million persons.

Today, the national office has 100 employees, and there are 65 million people enrolled in the 73 Blue Shield Member Plans.

ASSIGNMENTS: WHAT THE PHYSICIAN SHOULD KNOW

Questions are often asked about Medicare assignments. Basically, it is one of two methods of payments that Medicare allows. When the doctor bills the patient, payment will be made to the patient. This is direct billing. However, payment can be made directly to the physician when he accepts assignment. The choice of which method to use is left to the physician if he bills his patient directly or to the physician and patient when he accepts assignment.

When a physician and his patient agree to the assignment, the physician agrees that the reasonable charge determined by the Part B Medicare carrier will be payment in full and that his charge to the patient will be no more than the 20 percent coinsurance rate of the reasonable charge and any portion of the unmet \$50.00 deductible. Medicare will pay the other 80 percent. However, the physician may bill the patient for any services not covered by Medicare.

ASK BLUE SHIELD

• • • ABOUT MEDICARE

Labs Outside Your Office Must Be Identified

Whenever a physician submits a claim for an office visit which includes charges for laboratory tests made outside his office, the laboratory must be identified on the SSA-1490, Medicare Claim for Payment form.

If the laboratory is not approved, the claim for laboratory services must be denied. However, this does not affect the coverage of the office visit which usually includes the physician's charge for evaluating and interpreting the laboratory report. These will be covered in the usual manner, regardless of whether the laboratory claim is paid or denied.

The agreement to accept an assignment for one patient does not obligate the physician to accept the assignment for his other patients, nor for that same patient for a later service.

If the physician accepts assignment, he should obtain the necessary information from the patient to complete Part I, items 1 through 6 of the SSA 1490, Request for Payment form and obtain the signature of the patient on the form in item 6. The physician or his office assistant must provide the remaining information in Part II of the form.

The claim form must be complete, including the signatures of the patient and physician in every assignment claim. Be sure to check mark in the item 12 "I accept assignment" box, to show that the physician and his patient have agreed to the assignment. If the box is not checked, payment will be made to the patient.

To avoid unnecessary delays in payment, be sure to include the following information:

1. Date of service;
2. Place where service was performed (hospital, office, home, etc.);
3. Description of service;
4. Nature of illness or injury;
5. Charge for each service.

SSA Certifies New Laboratories

The following laboratories have been certified for Medicare participation by the Social Security Administration:

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Chicago, Illinois 60647

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1609 Fourth Street
Peru, Illinois 61354

Northwest Medical Laboratories
2006 West Chicago Avenue
Chicago, Illinois 60622

The actions of the official
Tincture and Extract of
Belladonna result chiefly from
their Atropine content . . .
conclude Goodman and Gilman

THE PHARMACOLOGICAL BASIS OF THERAPEUTICS
3rd Edition, page 522



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Legislative KEY-MAN program created

The ISMS Public Affairs Committee recently approved the development of a new and exciting legislative KEY-MAN program.

The KEY-MAN program was created with the thought in mind that a good deal of past legislative effectiveness and success can be attributed to grass roots physician participation. The importance of a personal physician/legislator relationship cannot be over emphasized.

This new plan calls for at least one physician to be assigned to each of the 24 Illinois Congressmen, 58 State Senators, and 177 Representatives. Needless to say, the designated KEY-MAN must be a constituent of the Legislator, and hopefully he knows or will get to know his Legislator on a first name basis. He will communicate with his legislator regularly so that the legislator knows exactly where medicine stands on various issues. The ISMS Legislative Division will be in constant contact with the KEY-MAN through various means—placing him on a special mailing list to receive legislative alerts—regular issues of *On The Legislative Scene* during the Legislative Session—via telegram or telephone.

In matters of state legislation, the control by one political party in the Legislature has never had too significant an effect on the outcome of the Medical Society's legislative program. We have many friends on both sides of the aisle. Through this new system we hope to communicate more effectively with all Illinois legislators regardless of party affiliation.

Are you personally acquainted with one

or more of our Legislators? Perhaps you are the personal physician of a Legislator! If so, you are urged to submit this information to the ISMS Legislative and Public Affairs Division, Regional Office, and volunteer your services as a KEY-MAN. The success of this new and challenging program can only be achieved through the efforts of a large number of physicians who are willing to take the time to become informed on legislative and public affairs matters and ACT.

KEY-MAN SYSTEM QUESTIONNAIRE

Are you personally acquainted with your Congressman, State Senator or Representative?

.....yesno

If so, please give names

Are you the personal physician of a Legislator?

.....yesno

If so, please give name

Would you be willing to serve as a KEY-MAN for one or more Legislators?

.....yesno

If so, please list names:

If you are not willing to serve in this capacity, please recommend other physicians from your area:

name & address Legislator

name & address Legislator

Your name

Address street, city, zip

Telephone No.

Return to: John Ovitz, M.D., Chairman
Public Affairs Committee
Illinois State Medical Society
Regional Office
520 So. 6th Street
Springfield, Illinois 62701

ON THE COVER

This month's cover is probably best described in lyrics from a song of the 1940's, "Tis Autumn."

"The trees say they're tired, they've borne too much fruit,
Charmed on the wayside, there's no dispute;
Now shedding leaves, they don't give a hoot,
.....Tis Autumn.

Cover art by Mike Ahearn.

Clinics for Crippled Children Scheduled

Twenty-four clinics for Illinois's physically handicapped children have been scheduled for December by the University of Illinois, Division of Services for Crippled Children. The Division will count seventeen general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing service. There will be five special clinics for children with cardiac conditions and rheumatic fever, and two for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

December 1 Alton—Alton Memorial Hospital
 December 2 Carmi—Carmi Township Hospital
 December 2 Hinsdale—Hinsdale Sanitarium
 December 2 Rock Island Cerebral Palsy—3808 Eighth Avenue
 December 3 Effingham—St. Anthony Memorial Hospital
 December 3 Litchfield—Madison Park School
 December 3 Lake County Cardiac—Victory Memorial Hospital
 December 3 Springfield General—St. John's Hospital
 December 4 Chicago Heights Cardiac—St. James Hospital
 December 8 Peoria—St. Francis Children's Hospital
 December 8 East St. Louis—Christian Welfare Hospital
 December 9 Champaign-Urbana—McKinley Hospital
 December 15 Belleville — St. Elizabeth's Hospital

December 15 Rock Island Area General—Moline Public Hospital
 December 16 Chicago Heights General—St. James Hospital
 December 16 Springfield Pediatric Neurology—Diocesan Center
 December 16 Aurora—Copley Memorial Hospital
 December 17 Rockford—Rockford Memorial Hospital
 December 17 Bloomington—St. Joseph's Hospital
 December 17 Elmhurst Cardiac—Memorial Hospital of DuPage County
 December 18 Chicago Heights Cardiac—St. James Hospital
 December 18 Evanston—St. Francis Hospital
 December 21 Peoria Cardiac—St. Francis Children's Hospital
 December 22 Peoria—St. Francis Children's Hospital.

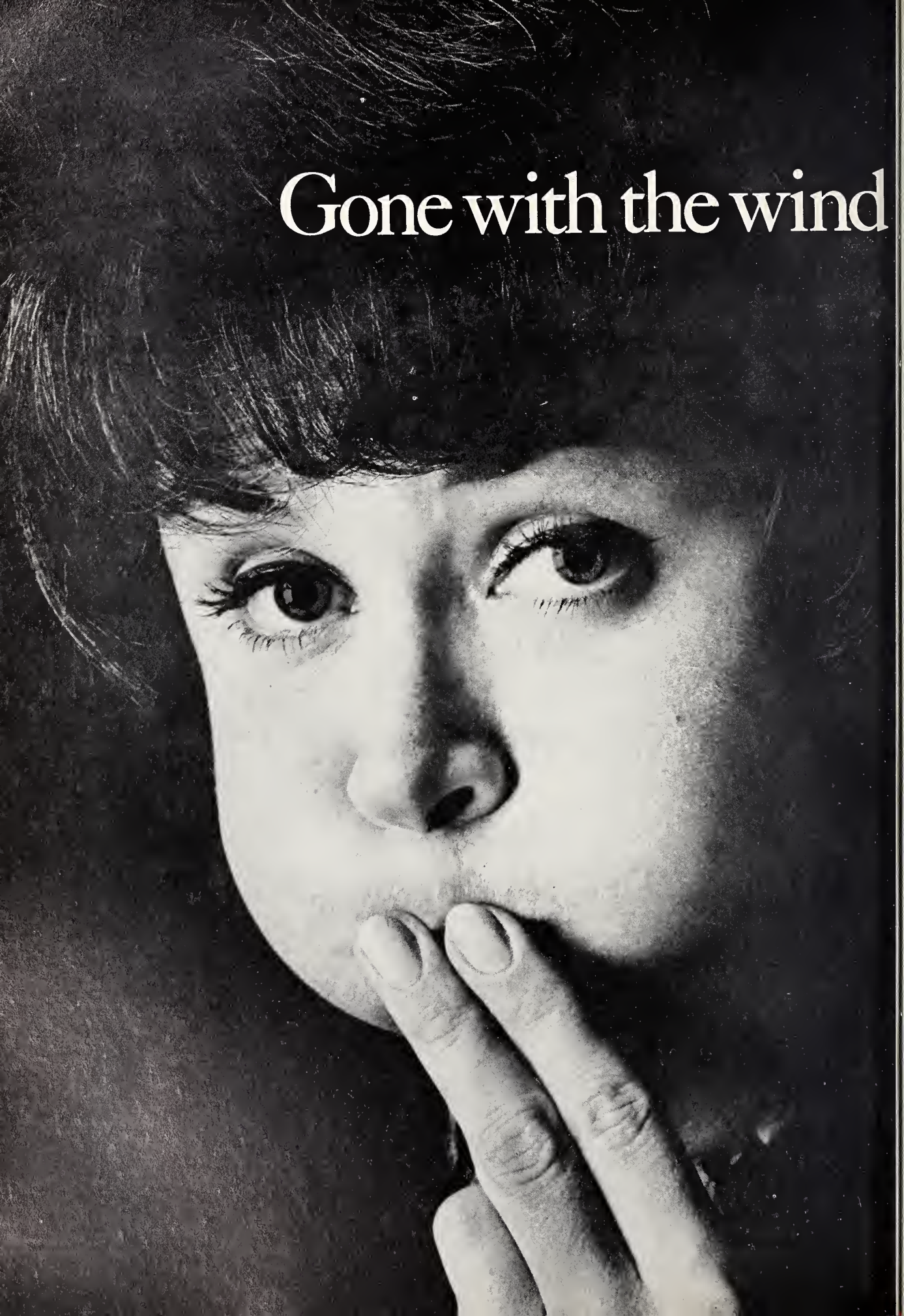
The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

The Danger in More Taxes

"Approximately 35 to 37% of the total income of the United States goes to federal, state and local taxes. I believe that amount is high enough. I believe that when a nation takes a substantially larger portion of the national income than that for taxes, that nation loses its character as a free private enterprise economy and becomes primarily a state-controlled and oriented economy." President Richard M. Nixon.

Gone with the wind



The patient who has had a myocardial infarction is usually advised by his physician to avoid emotional excitement. All too often his family, acutely concerned, transmits its anxiety to him, urging him to "rest, rest."

How anxiety may interfere

In a study of 336 males who had suffered at least one myocardial infarction, Sigler¹ reports that manual workers showed the lowest percentage of patients returning to work, compared to clerical workers, business and professional men. The author notes that in many cases the mere apprehension that "return to work would shorten life prevents the patient from resuming activities." It is also well known that emotional disturbance is probably the most common cause of cardiac disability in postinfarction cases.¹

The anxiety factor in both *coronary* and *precoronary* patients has recently been discussed by Thomas,² who suggests: "Intensive investigation of the sources and kinds of anxiety, and how destructive forms of anxiety can be identified and relieved may be the next important step in the prevention of coronary heart disease."

Relief of anxiety with Librium® (chlordiazepoxide HCl) often proves a valuable adjunct to medical counsel, reassurance and the total management program; may help prevent the postcoronary patient from regressing into a state of invalidism.

As an adjunct in cardiovascular therapy, Librium® (chlordiazepoxide HCl): Quickly relieves anxiety of mild to severe degree in most cases. Helps expedite cooperation in therapeutic regimen. May be used concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, antihypertensive agents

and diuretics. By relieving anxiety, helps encourage productive activities. Has a wide margin of safety and, in proper maintenance dosage, seldom impairs mental acuity or ability to function. Often effective in extended therapy, usually without diminution of effect or need for increase in dosage—in protracted use, periodic blood counts and liver function tests are advisable.

References: 1. Sigler, L. H.: *Geriatrics*, 22:(9) 97, 1967. 2. Thomas, C. B.: *Johns Hopkins Med. J.*, 122:69, 1968.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating

drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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J. Ernest Breed

The President's Page

Allocation of the AMA dues dollar . . .

Last June the House of Delegates of the AMA approved the \$40 increase in dues for 1971. This will raise the dues from \$70 to \$110, the first increase since 1967. No one should be surprised that an increase is necessary since inflation alone at about 8% a year would make it mandatory. There are many reasons of which you may not know. The major reason is the government tax of 48% on "unrelated income" for all not-for-profit organizations, such as medical societies and the Boy Scouts. Ten years ago, 50% of the AMA income came from advertising, and 43% from dues. This year 39% of the income comes from dues and 34% from advertising in the AMA publications.

Two years ago, the House of Delegates approved a statement calling for intensified leadership by the AMA in medical problems of public concern. These include all kinds of problems, such as physician shortages, national health insurance, environmental pollution, nutrition and health care delivery. In addition to the problems of public interest, it has been necessary to provide new services to the profession it-

self, such as an increase in medical schools, continuing education for doctors in practice, professional liability insurance, advice in malpractice claims, accreditation of hospitals and the AMA retirement program, just to mention a few.

To provide all these services, in addition to many other programs, requires new personnel. In 1967, there were 982 employees and now there are just over 1,000, but the professional help has increased 13%.

This year the operating expenses will be over \$32 million, which includes \$25 million for programs, \$1.5 million for office space and \$6.7 million for administrative costs. Inflation alone will probably add another \$2 million a year for the next few years.

Economies have been installed, including discontinuation of the AMA Research Foundation and holding fewer committee meetings whenever possible. All members, however, realize the absolute necessity for a strong AMA to guide us through these trying times when tremendous changes are being made in the world of medicine.

University of Illinois accepts \$500,000 In grants at the Medical Center

The University of Illinois Medical Center Campus, Chicago, has accepted an overall total of \$542,349 in research and training grants for the month of September. Out of 17 grants listed, 14 grants totaling \$236,556 were from the United States Public Health Service.

The funds were allocated as follows: \$5,142, College of Dentistry; \$236,556, College of Medicine; and \$300,651, Student Affairs.

The largest single grant, \$139,814, was awarded to Dr. Donald A. Boulton, dean of Student Affairs, by the United States Public Health Service to be used for the Health Professions Scholarship Program in Medicine.

Encephalitis with Catatonic schizophrenic symptoms

BY CHANG HWAN KIM, M.D., AND MEYER A. PERLSTEIN, M.D.* / CHICAGO, ILLINOIS

The decision to give anti-rabies vaccine, after a bite by a stray animal, should be carefully considered since the incidence of rabies in all untreated bites is very low (less than 1:50,000) as compared to the incidence of lethal reactions from anti-rabies vaccine. The incidence of rabies in all untreated bites varies from 3 to 40 out of an estimated 2 million animal bites per year.¹ Since World War II, the incidence of human rabies in the United States has ranged from a high of over 40 persons per year to a low of three.² In the last decade only one or two human cases have occurred each year.³

The incidence of reaction to anti-rabies vaccine, on the other hand, varies from 1 in 146 persons⁴ to 1 in 8,287 persons.⁵ Some of the reactions are of an allergic type with itching, rashes and general signs of allergy. Neuroparalytic complications occur in 1:287⁶ or 30 per million to 1 of every 1,000 patients⁷ given treatment.

When paralytic symptoms occur, the mortality may be 20 to 30%.^{8,9} When the symptoms become encephalitic the mortality rises to 50%.¹ Taking the highest figure for the incidence of rabies in untreated bites, 20 in a million, and comparing fatalities for rabies vaccine, 300 per million, the chances are 15:1 higher that death will occur from the vaccine than from rabies. Most of the reactions that have occurred have been reported following the use of anti-rabies vaccine grown in the rabbit brain (Semple vaccine). The incidence of these side effects has been lessened by the use of duck-embryo-grown vaccine. When the symptoms of anti-rabies vaccine sequelae are paralytic or allergic, the diagnosis is relatively simple. When presenting as a psychiatric syndrome, it may be confusing. Sobin and Ozer¹⁰ reported 10 patients with acute (non-vaccination) encephalitis with psychiatric symptoms. Two of them manifested schizophrenic catatonia. The differential diagnosis between encephalitis and schizophrenia was extensively documented by Hollende et al.¹¹

We have seen a case in which the clinical picture of catatonic schizophrenia following Semple anti-rabies vaccine therapy developed.

Case history

An 8-year-old Negro boy was admitted to the Children's Division of Cook County Hospital on 7/21/67. About 3 weeks before admission he was bitten in the left leg by a stray dog in the playground of his house.

The dog remained undetected. He received 14 consecutive daily injections of Semple anti-rabies vaccine at the Municipal Contagious Disease Hospital. After the eleventh injection he became listless and agitated. He paced back and forth, raising and dropping his hands. Marked personality changes soon became evident; he became extraordinarily talkative and hyperactive. On July 19, two days before admission and five days after the fourteenth dose, he had a generalized convulsion, followed by low grade fever and vomiting. His gait became ataxic and he complained of numbness in his legs. He developed visual hallucinations (fire, bubbles). He had no difficulty in drinking and swallowing.

On admission, he was non-ambulatory, mute and immobile. He was well-nourished and developed. He weighed 67 lbs., rectal temperature 99°F, blood pressure 100/70 mm. Hg. He was withdrawn and did not respond to verbal commands. Occasionally he moved slowly. His eyes constantly stared, neck was slightly stiff, extremities were held stiffly, pupils were moderately constricted but reacted to light, and ocular fundi were normal. Deep and superficial reflexes were all present and normal on admission. No other neurological abnormalities were noted. Exteroceptive and proprioceptive sensory function could not be assessed because of the patient's severe withdrawal. The original diagnosis lay between a modified rabies or a post-vaccinal reaction.

Laboratory work showed a WBC count of 8,600 per cubic mm. with normal differential, hemoglobin of 12.5 Gm. %, blood urea nitrogen of 29 mg. % and normal electrolytes for sodium, potassium, chloride and CO₂ combining power. Kahn and Wasserman tests were negative. Routine urinalysis was normal. Spinal fluid on the ad-

mission and the twelfth hospital day showed no cells but slightly increased sugars of 76 and 92 mg.% respectively. Protein and chloride were normal. Culture of both spinal fluid and blood showed no organisms. No pathology was seen in skull and chest X-rays. Serum antibody to rabies vaccine done by the Public Health Service in Atlanta, Ga. showed positive titer in dilution of less than 1:50, a positive response to vaccine, against 21 MLD50, indicating the patient was protected against rabies.

An E.E.G. on the fifth hospital day showed a slow wave focus in the left parietal region spreading to the left frontal and occipital areas but no seizure activity.

By the second week of hospitalization the patient was so severely withdrawn that no response could be obtained to verbal commands or visual and tactile stimuli. He continued to stare at the ceiling with a "far-away-look." When his arm or leg were raised, they retained the position. A provisional diagnosis of Schizophrenia, Catatonic type, was made by a consulting child psychiatrist at this time.

During the following five days the patient convulsed frequently. The seizures lasted for about five to eight minutes, starting in the left arm and becoming general. Another E.E.G., a week later, showed Grand Mal seizure activity while the patient continued to have frequent seizures.

Treatment with corticosteroids was instituted from the day following admission. It was started with Solu-medrol, 20 mg. I.M., every eight hours, for two weeks and switched to prednisone, 25 mg. orally, every eight hours, for the following three weeks and tapering off over the next two weeks. Paraldehyde, 5-7 ml. rectally and phenobarbital sodium, 30 mg. I.M., twice a day, were used during the ensuing days for control of seizures. Chlorpromazine was stopped after only three days, 25 mg. three times a day, because it seemed to have no effect on the child's catatonic condition.

The patient began to improve by the third week. He was able to sit in a chair and feed himself. At this time he walked with a staggering gait and had intention tremors in the arms. He responded poorly to the commands for the examination of sensory function. However, his stiffness became less and he became more visually aware of his environment. E.E.G. at this

From Children's Neurology Service, Cook County Hospital, and Hektoen Institute for Medical Research, Chicago, Illinois. Supported in part by Grant-CF-73-67C, United Cerebral Palsy Foundation.

time showed marked improvement with the subsidence of seizure activity. He was less withdrawn but still had allalia at the time of discharge, after six weeks of hospitalization.

Discussion

The differential diagnosis on admission was between an atypical rabies due to the inadequate effect of vaccine therapy and a postvaccination encephalopathy. Since the patient developed no signs of rabies such as excitability and laryngeal spasm in the ensuing days, that diagnosis was eliminated.

The absence of signs of paralysis in the lower extremities and bladder or bowel dysfunction ruled out a primary myelitic involvement. The diagnosis of encephalitis was made on the basis of the history of onset toward the end of rabies vaccination and presentation with fever, seizure and stiffness of neck and extremities. The outstanding symptoms of hallucination, withdrawal, catatonia and mutism were sufficient for the diagnosis of catatonic schizophrenia. Such psychiatric symptoms are not rare in organic cerebral diseases but are rare in post-vaccinal encephalitis.

The marked personality changes that first occurred in this case were not primarily catatonic, but intense irritability and listlessness were noted.

Nichols,⁸ 1946, reported two cases of post-vaccinal encephalitis due to rabies vaccine whose mentation changes were initially preceded by nervousness and irritability. One patient developed a maniacal mental disorder; much crying, excessive laughing and talking but no catatonia.

Various psychiatric symptoms are noted in many pathologic conditions of the C.N.S. Akinetic mutism was first described by Cairns et al¹² in a patient with an epidermoid cyst of the third ventricle and posterior fossa tumor, especially of cerebellum. Other causes of akinetic mutism are brain

stem lesions due to thrombosis of the basilar artery, tumors, trauma, viral infections, cysts, and malaria.¹¹

Catalepsy in animals caused by bulbocapnine was reported as far back as 1892.¹³

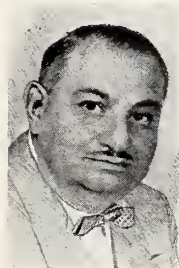
Psychiatric changes such as depression, premature dementia, and neurasthenia are reported in certain neurocutaneous diseases: Pseudoxanthoma elasticum, Keratosis Follicularis (Darier's Disease).¹⁴

Striking psychiatric changes were frequent in epidemic encephalitis of von Economo.¹⁵⁻¹⁹ They have not been observed as frequently in other types of encephalitis.²⁰⁻²³ Minor psychological changes such as impaired concentration, amnesia, easy forgetfulness, confusion, nightmares and nocturnal emission have been observed in the patients treated with Semple anti-rabies vaccine,²⁴ but none of the syndromes were seen in our patient.

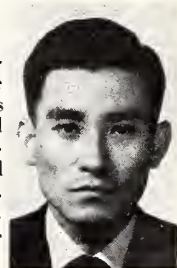
The patient reported here manifested the classical symptoms of catatonic schizophrenia: withdrawal, non-responsiveness, hallucination and immobility following 14 consecutive treatments of Semple rabies vaccine made of rabbit brain. To our knowledge, this form of a post-rabies vaccinal encephalitis is unique.

It was possible to make the diagnosis of encephalitis as the underlying process in this case with the presenting objective neurological findings of stiffness of neck and extremities, constriction of pupils, and the seizures with positive electroencephalographic change. Hollander et al¹¹ discussed the problem of differential diagnosis of encephalitis and psychiatric symptoms, particularly of the catatonic type of schizophrenia.

The vaccine given in this case is Semple type which is prepared with phenol-killed virus grown in rabbit brain. Although it induces a higher degree of antibody synthesis²⁵⁻²⁷ it causes more neuromuscular complication than duck-embryo grown vi-



Chang Hwan Kim, M.D. (right), is a pediatric neurology consultant, Reed-Chicago State Hospital. He is a graduate of the Yeun Sei Univ. College of Medicine, Seoul, Korea, and served his internship in Albany, N.Y., and a residency at Jefferson Medical College Hospital, Philadelphia. In addition he has done fellowship work in pediatric neurology under the United Cerebral Palsy Foundation at Cook County Hospital. M. A. Perlstein, M.D. (left), was professor of pediatrics at Northwestern Medical School and head of Pediatric Neurology at Cook County Hospital. Dr. Perlstein died recently in California.



rus. The frequency of severe encephalitis due to this vaccine varies from 1:1,000 to 1:4,000 persons given treatment.^{9,28-30} The mortality of encephalitis due to this vaccine varies from 30%⁹ to 50%.¹ Survivors usually manifest few permanent sequelae.³¹

The most common neurological complications of rabies vaccination are:

1. Peripheral neuritis, especially facial, usually ending in complete recovery.
2. Lumbar myelitis with low mortality rate.
3. Encephalomyelitis with Landry's ascending paralysis with a high mortality rate due to bulbar paralysis.^{6,24,32}

The autopsy findings mainly show focal demyelinating process with associated perivascular inflammation. The evidence of neurological complication usually develops from the fourth to fourteenth day of injection. However, Ford³³ reported a case which occurred four months after vaccination. In general, more severe cases appear earlier than milder ones.

W.H.O. Expert Committee on Rabies recommends the switch from Semple to avian-embryo vaccine when premonitory symptoms indicating neuromyolytic complications develop.³⁴⁻³⁶ A comparison was made of the general and local reactions duck-embryo rabies vaccine and Semple brain-tissue rabies vaccine in 123 patients by Greenberg and Childress³⁷ in 1960. In their study, the complication of encephalomyelitis did not occur in two patients who received the vaccine containing brain tissue. Neuromyolytic complications occurred in 44 patients treated with brain tissue rabies vaccine in the anti-rabies clinics of the New York City Department of Health from 1828, to 1951.³⁸

Clinical effect and the experiences in human use of the duck-embryo vaccine have been studied.³⁹⁻⁴³

Sharp and McDonald (Britain, 1967)²⁴ recently reported 20 cases showing various reactions following the Semple rabbit-brain vaccine. The two of these 20 patients were severely ill and many of them suffered from various mental symptoms. None of them showed schizophrenic reaction.

The patient in the present report has recovered with the alleviation of neurologic signs and schizophrenic symptoms after five weeks of treatment with corticosteroids.

Although the phenothiazines are known to be effective in the treatment of schizophrenia (catatonic and paranoid type),⁴⁴ chlorpromazine, which was given to this patient, was discontinued after three days trial because it seemed to enhance the catatonic condition. Actually the catatonic condition may have been a form of extrapyramidal rigidity due to involvement of basal nuclei by the encephalitic reaction and thus may have been aggravated by the thorazine.

Briggs and Brown⁶ reported a case which showed dramatic response to the treatment with corticosteroids which developed the signs of a profound degree of encephalomyelitis. Their patient did not present any mental symptoms. They treated the patient with 100 mg. of hydrocortisone, I.V., which was followed by 25 mg. of prednisolone orally four times a day. Blatt and Lepper⁴ reported three patients treated with A.C.T.H.; two of whom also showed dramatic response.

This report emphasizes the danger of the everlasting, undesired adverse reaction to anti-rabies vaccine, especially of the preparation of brain tissue, which often causes not only fatal neuromyolytic complications but also severe psychiatric change.

Summary

1. A patient with an unusual clinical reaction to the Semple antirabies vaccine is reported.
2. The picture was that of Catatonic Schizophrenia with underlying encephalitis. The patient gradually improved on corticosteroids.

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Women Are Wage Earners for One-fifth of Households

When mother is the bread winner, the bread is sliced thinner, a recent survey reported by the National Consumer Finance Association reveals. Women are now wage earners for 20% of all U.S. households, and earn an average of nearly \$5,000 a year less than male counterparts. Their average yearly income is \$4,278, as compared to \$9,195 for households headed by males.



THE VIEW BOX

BY LEON LOVE, M.D.

*Director, Department of Radiology, Loyola University Hospital
and Chairman, Department of Radiology, Loyola University
Stritch School of Medicine*

This 50-year-old male patient entered the hospital complaining of acute difficulty in swallowing and noted that he had been fine until he had eaten a steak about twelve hours previously. At the time of admission, there was continued regurgitation and the patient was in acute distress. The physical examination was otherwise unremarkable. What's your diagnosis?

1. Carcinoma of the distal esophagus
2. Peptic esophagitis
3. Steak eaters disease
4. Sarcoma of the distal esophagus

(Answer on page 558)

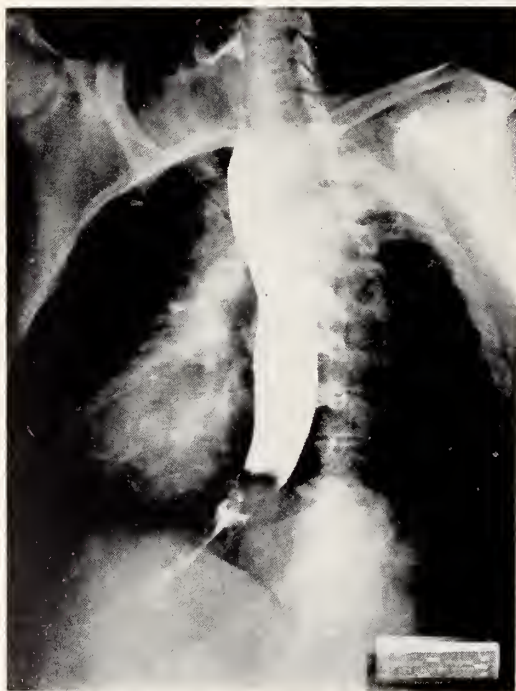
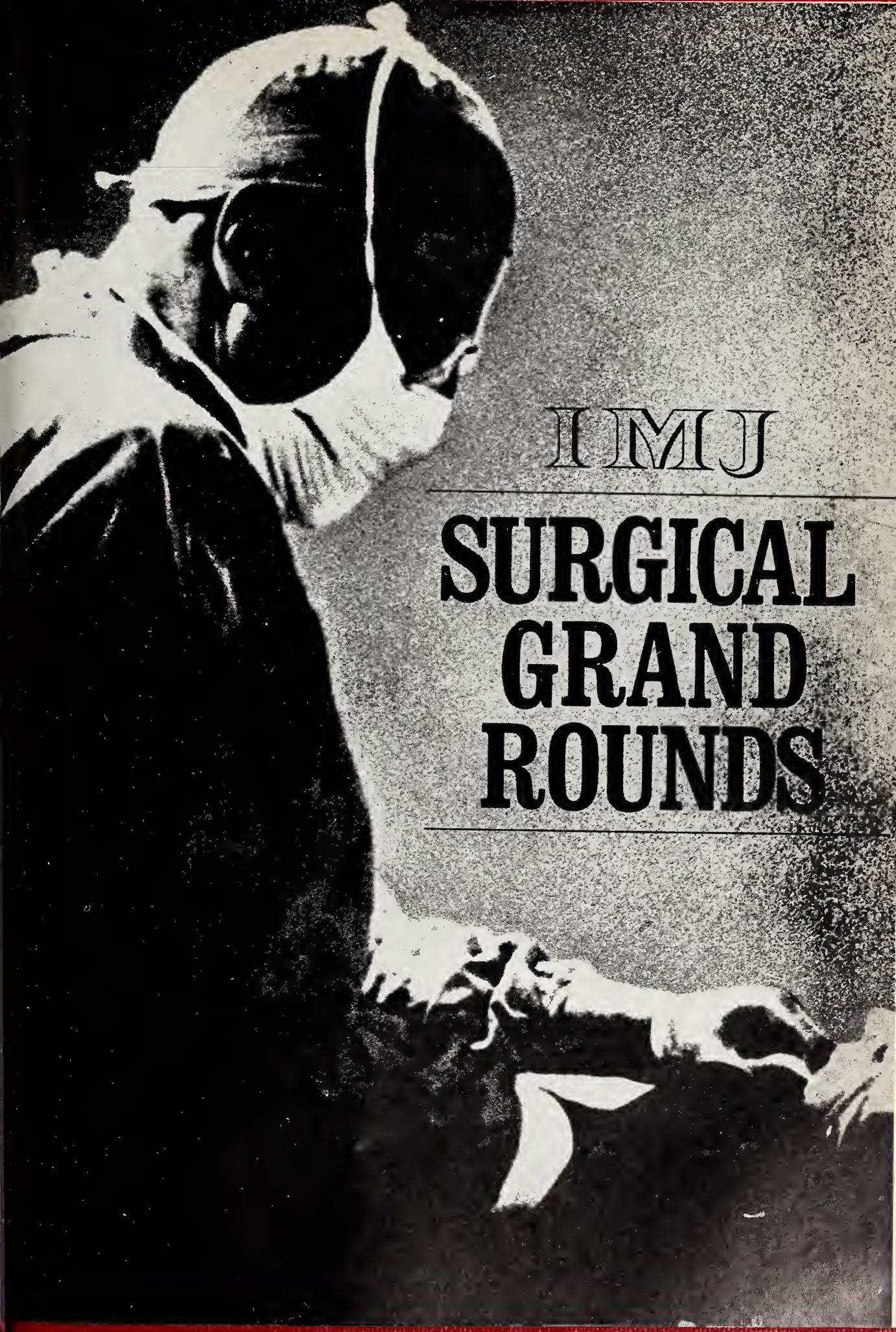


Fig. 1



Fig. 2



IIIMJ

SURGICAL GRAND ROUNDS

Surgical Grand Rounds are held weekly on Saturday at 8:00 a.m. in the Offield Auditorium at Passavant Memorial Hospital. Patient presentations from Chicago Wesley Memorial, Passavant Memorial, and the Veterans Administration Research Hospitals form the basis of the discussions. This case report was part of the Surgical Grand Rounds held on January 24, 1970.

Acoustic neuroma

EDITED BY JOHN M. BEAL, M.D.

Case Report:

Dr. Bernard Feldman: A 58-year-old white female was admitted to Passavant Memorial Hospital January 5, 1970 with a chief complaint of a roaring, humming noise in her left ear for the past two years. Approximately two years before admission, she noticed the gradual onset of tinnitus, associated with gradual but progressive hearing loss in the left ear. Several months prior to admission, she noted the onset of numbness and tingling on the left side of her mouth and a burning sensation on the end of her tongue. She denied any unsteadiness of gait, dizziness, or visual disturbances. A few weeks before admission, she noted the onset of a pressure sensation over her occipital area and the back of her neck.

Pertinent physical findings at the time of admission were limited to the neurological examination as follows: her left palpebral fissure was slightly wider than the right. On rapid lid fluttering, the left lid did not close as well as the right. There was slight left lower facial asymmetry on grimacing. Pain to pin prick and light touch was diminished over the entire left side of the face. There was diminished taste sensation to salt and sugar on the anterior two-thirds of the tongue on the left. She had decreased ability to hear in her left ear. Although

lateralization of the Weber test was absent, bone conduction was greater than air conduction in the left ear.

On January 13, she was taken to the operating room, where a posterior fossa craniotomy and total resection of her acoustic neuroma was performed by Drs. Raimondi and Kerth.

Immediately after surgery, she was alert and oriented, able to talk and responded quite well. The only abnormality initially was a left facial paresis. On the first postoperative day, she became progressively more obtunded and there was facial and periorbital edema. By the evening of the first postoperative day, she was quite obtunded and responded only to painful stimuli. A tracheostomy was performed in order to suction her secretions and to provide better aeration. On the second postoperative day, she was slightly better; however, on the third day, she showed dramatic improvement, became alert again, and was able to speak. She is now well recovered.

Dr. Joseph C. Sherrick: The specimen consisted of multiple fragments of yellow and light tan tumor, the largest measuring 2 cm. in maximum dimension. Microscopically the tumor consisted of spindle-shaped cells with their nuclei aligned in rows, the so-called palisading of nuclei. Parts of the

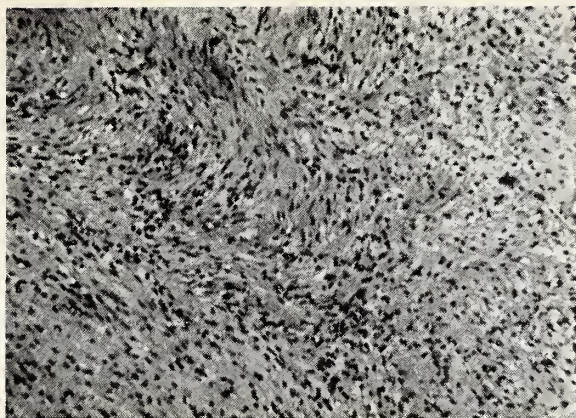


Fig. 1. Microscopic examination of the acoustic neuroma shows spindle-shaped cells with palisading of nuclei.

tumor were solidly cellular, Antoni Type A tissue, seen on the left side of Figure 1. Other areas are more loosely arranged and cystic, as seen in the upper right of Figure 1, and known as Antoni Type B tissue. These tumors are derived from nerve sheath cells and are called neurilemmomas. They may occasionally contain intermingled nerve fibers, which has led to the use of the term acoustic neuroma.

The portion of cerebellum we received showed no significant abnormality.

Dr. Jack Kerth: This patient demonstrates very typically the history and progression of an acoustic neuroma. First, she is a female. Acoustic neuromas occur about twice as often in females as they do in males. Second, her initial complaint and actually the only significant complaint throughout the year and a half that I followed her was a hearing loss on the left side. She had unilateral hearing loss only, without other symptoms, or other complaints. Her hearing loss was a pure sensorineural type without indication of the etiology. A number of audiometric tests are performed when we see a patient with a unilateral hearing loss. The main three tests in this battery are: (1) a test of the hearing level at 500, 1,000, 2,000 and 4,000 frequencies; (2) a determination of the patient's ability to understand spoken words such as yard, carve, ran, etc. This is a somewhat more complex task for the hearing apparatus than the frequency test. When I first saw this lady, this test was essentially normal. The other important test performed in patients in whom we suspect an acoustic neuroma, and anyone

who presents with a sensorineural loss unilaterally as a candidate for a neuroma, is the tone decay test. A pure tone, at 500, 1,000, and 2,000 frequencies is presented to the questionable ear and one determines how long the patient can hear this tone at the level presented. If there is tone decay, typically found in patients with a retrocochlear lesion, which an acoustic neuroma is, then the patient does not hear the tone for a standard period of time. Typically, one presents the stimulus at 15 decibels above threshold; it will be heard for 5 seconds and then disappear. In spite of increasing the intensity of the stimulus, it repeatedly fades in the ear of the patient. Thus the name, tone decay test. The normal person will hear this tone at the initial intensity for about 60 seconds. When first seen, this patient had only a unilateral sensorineural hearing loss without poor speech discrimination and without the tone decay. Other sophisticated audiometric tests may be performed, but they are not important for our discussion.

There are only about three other causes for unilateral hearing loss besides acoustic neuroma. One is Meniere's disease, or swelling of the endolymphatic system in the inner ear; another is cochlear otosclerosis—an abnormal growth of bone in the capsule of the inner ear. Then there is a relatively large category about which we know very little, and this is etiology undetermined.

At the time I first saw this patient, she did not fall into any known category. The only other test that we did originally was a caloric test. This was normal. Routine skull and mastoid X-rays at that time were not taken because of the relatively normal hearing and caloric tests. Most people—over 80%—who present with an acoustic neuroma will have a diminished caloric response. Because unilateral hearing loss may be secondary to an acoustic neuroma and that's one of the somewhat rare conditions that we can treat well when found early, we follow patients with unilateral hearing loss very closely. I was unable to follow this lady as closely as I would have liked; she came back, not at six months as she should have, but at nine months, and then she waited even longer before she would consent to continue with our diagnostic work-up.

In this interval of nine months, her symptoms did not really change. She noticed a slight progression in hearing loss, but that was about all. She did, however, show a dramatic change in her hearing tests. She had increased sensorineural loss. Her discrimination, which was around 96% initially, dropped down to about 50%. She now had tone decay and a diminished caloric on the left side. Thus, I was very suspicious of an acoustic neuroma and sent her for X-rays.

There are a number of types of X-rays that one can order for patients such as this lady. The routine skull X-rays taken at the routine hospital by the routine X-ray department frequently do not show an acoustic neuroma of small to medium size. They'll show large ones with significant

doing the test is familiar with the procedure, then there is something occluding the canal. It may be a neuroma, a meningioma, some type of cyst, or it may be adhesions from an old arachnoiditis; there is some abnormality there.

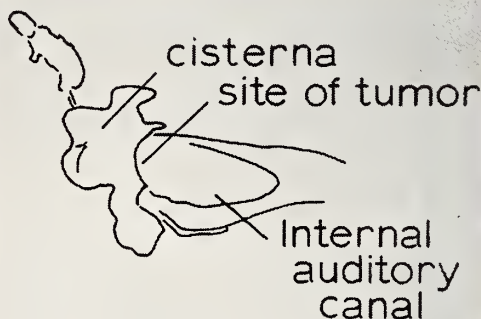
In the patient presented today, the contrast agent did not fill the internal auditory canal and there actually was a rounded mass protruding from the canal (Figure 2). Although the obstruction of the internal auditory canal did not have to be a neuroma, 80 to 90% of the tumors or obstructions in this region are acoustic neuromas.

Presentation of the patient

The patient was 10 days postoperative. A left-sided facial paralysis was demonstrated. (At the termination of the opera-



Fig. 2. The posterior fossa myelogram demonstrates the mass protruding from the internal auditory canal.



erosion of the internal auditory canal, but not a small to moderate sized neuroma. Laminograms are an improvement, but there are X-rays which are somewhat more sophisticated than the laminograms. These are called polytomograms. They are taken with a very specialized type of machine. The ultimate diagnostic tool and one step more sophisticated than the polytomogram is a posterior fossa myelogram combined with polytomography. This is performed by injecting 1-2 cc. of a radiopaque dye into the subarachnoid space, tilting the patient's head down, and visualizing the posterior fossa. The main objective in this study is the outlining of the internal auditory canal with the dye. In experienced hands, practically 100% of the time this can be done. If the dye will not run into the internal auditory canal and if the person

tion, just prior to closure, the facial nerve had been stimulated and good facial movement resulted. Facial function can be anticipated within the next six months.) The patient walked in tandem and had moderate difficulty with this. (Patient leaves.)

Dr. Anthony Raimondi: This patient shows how far we have come in the management of this kind of tumor. In the time of Harvey Cushing, this tumor was considered inoperable. This held true until the early 1940's, with the exception of Dandy, who had published something like 50 or 60 cases with a 5-10% mortality, and then went on to do well over 400 or 500, maintaining roughly the same mortality. The morbidity which he encountered was, however, what we today would consider prohibitive. He automatically accepted a VII paralysis; he accepted a V paralysis; the

VIII was inevitable, as it is at this time; he would accept, gladly, a paralysis of IX, X, XI and XII, plus a hemiplegia. It was standard operating procedure to do a tarsorrhaphy postoperatively because the patients were considered to have at least a V nerve palsy, lest they suffer corneal ulcerations.

Then, with the advent of three things, we have come to the present time. One is the ability of the otologists to make a presumptive diagnosis of an acoustic neuroma in something like 95% of the patients. The second is the ability of the radiologist, using polytomography and pantopaque cisternography, to confirm the diagnosis in almost 100% of the patients, and beyond that, to give a clear idea as to the size and extent of the tumor. This permits the surgeon to plan his flap and the degree of surgery (at least the destructive element of the surgery) in a much more meaningful way. The third thing is the advent, again from the otologist, of the operating microscope, so that this tumor may be dealt with in a microscopic fashion, consequently assisting us in avoiding the anterior inferior cerebellar artery, which is really what causes many postoperative deaths. We once occluded the anterior inferior cerebellar artery unknowingly, thus giving the patient an infarct of the pons. That night the patient would develop a clinical picture which looked like shock, but, in essence, really signified that the pons infarcted. The microscope gives us the opportunity to save the VII cranial nerve in these patients, so that they do not have permanent deformity, necessitating a nerve graft and then requiring the patient to learn to lift the shoulder or move the tongue in order to get movement on that side of the face.

With the collaboration between otologists and neurosurgeons, the last phase was the development of a surgical technique which would make this type of surgery meaningful and available to more institutions.

Here, really, what we did was just a standard posterior fossa opening. The tumor was considerably larger than the radiologist had predicted, but it was still at least not so large that we couldn't deal with it effectively. After I took off the lateral third of the cerebellum, electively, in order to have good exposure and in order not to retract on the brain stem, Dr. Kerth opened

the petrous pyramid. He opened the medial third of it and thus allowed for the identification of tumor. He pointed out the VII nerve to me, and then I took over the dissection, lifting the tumor off the VII nerve and carrying the dissection medially, with Dr. Kerth coming in from time to time to look again at the VII nerve out distally in the petrous pyramid and then medially coming off of the pons. In this manner we were able, by using the operating microscope and by working in tandem, to take what amounted to a plum-sized tumor out of the angle, off of the pons, and away from the VII cranial nerve, saving this nerve entirely. At the end of surgery, stimulating the VII cranial nerve at its exit from the pons, we got a full grimace on the left side. This paresis, rather than palsy, that she has of her VII nerve now, is certainly transient. She already has some "pucker" and some "flicker" of movement on the left side, and she most probably will have quite good facial movement postoperatively.

Dr. John Beal: Why do you take off part of the cerebellum? Does it leave any defect?

Dr. Raimondi: The lateral third of the cerebellum leaves no permanent defect. Postoperatively, she had nystagmus of a curious kind, in that the rapid component of the nystagmus was to the inappropriate side. Dr. Drachman got very excited about this. It has since cleared, as has her nystagmus. She'll recover totally from any evidence that we would attribute to the lateral third of the cerebellum. Her difficulty now, I think, is still pontine and not cerebellar. One does very well without the lateral third of the cerebellum. The reason for taking it off is to have adequate exposure. With inadequate exposure, one ends up retracting, and, if you retract on the brain stem, you get swelling and then lose the patient. In order to get the tumor out, one takes what, really, the patient can do very well without.

Dr. Beal: Do you remove the entire tumor or part of it?

Dr. Raimondi: Without the operating microscope, this most certainly would have been considered, by me—a total resection. With the operating microscope, I'd have to estimate that we left somewhere between an eighth and a quarter of a gram. There is no tumor left, as I would consider tumor,

(Continued on page 560)

The wound that killed Lincoln

BY JOHN K. LATTIMER, M.D./NEW YORK

Chronology of the hours after the shooting

Time (Close approximations)

- 10:13 p.m. Lincoln shot
Clot on left shoulder but very little ooze from wound at first.
- 10:20 Wound probed by finger of Dr. Leale to depth of two inches.
- 10:30 Moved to house across the street from theatre—clots evacuated repeatedly to relieve breathing.
- 10:50 Brandy apparently swallowed—one pupil contracted—one pupil dilated; both unresponsive to light.
- 10:55 Pulse 48
- 11:00 Brandy not swallowed—left eyelid echymosed—pulse 42 and weaker.
- 11:30 Right eye socket filled with blood with great protrusion of eye—pulse 45.
Twitching of face on left for 20 minutes; mouth drawn slightly to left.
- 1:00 a.m. Spasmodic contractions of muscles, pronation of both forearms—both pupils became widely dilated—stayed so until death—breath held during spasms—pulse to 100.
- 1:30 Pulse 95
- 2:00 Silver probe passed by Dr. Barnes—hit plug of skull at three inches (verified at autopsy) too short to follow whole length of track. Nelaton probe in 5 inches and struck the left orbital plate. (Taft)
- 2:32 Pulse 54
- 5:30 Oozing of fluid, blood and brain tissue ceased—breathing stertorous—pulse 64 and thready—respirations 27.
- 7:21 &
55 sec. Breathing ceased.
- 7:22 &
10 sec. Pulse inperceptible.
- 12:10 p.m. Autopsy performed at the White House in Lincoln's bedroom.

One hundred and five years ago, President Lincoln was sitting in a rocking chair in a box at Ford's Theatre in Washington, watching a play on Good Friday evening.

If General Grant had accompanied President Lincoln to Ford's theatre on the night of April 14, 1865, President Lincoln would not have been shot. General Grant's large military bodyguard was specifically instructed in the matter of preventing assassins from approaching their Commander, and it is doubtful that Booth could have gotten close to either man. Unfortunately, Mrs. Grant did not like Mrs. Lincoln, and persuaded the General to renege on his acceptance of the invitation, even though it had been announced in the newspapers early in the day. Washington was still celebrating Lee's surrender, five days earlier, at Appomatox, and Grant was the conquering hero. Everyone was delighted that he might appear at the theatre with the Lincolns that evening^{1,2} and people flocked to buy tickets.

At about 10:00 p.m., just after the second intermission, a dashing young actor, who was a known Confederate sympathizer, named John Wilkes Booth, entered the front door of the theatre, bantered with the ticket-taker, who knew this popular actor well, and ascended rapidly to the dress circle. There he paused for a moment while he selected a letter or visiting card from several in his pocket, to show to anyone who might challenge him, and advanced toward the door of the Presidential box.

John Wilkes Booth approached the box according to a prearranged plan in which he was to kill Lincoln, while an accomplice, Payne, was to kill Secretary of State Seward simultaneously. Booth was able to get into the box through a series of fortuitous coincidences, barricaded the door of the box with a device he had secreted there earlier, and surveyed the box through a peephole he had made. He was able to step briskly through a door of the anteroom and point the pistol at Lincoln's head, without hesitation. Lincoln had twisted his head sharply away, at the moment the shot was fired.

Thus, the bullet entered the left side of the occiput, even though Booth was approaching Lincoln from Lincoln's right. The six inch, easily concealed, percussion Derringer was of a type which fired a large ball, almost $\frac{1}{2}$ inch in diameter, of relatively low velocity but with the force of a sledgehammer. A one inch disc of bone was driven three inches into the brain, and the ball traveled through the brain a distance of seven and one-half inches, to lodge above one eye. A fragment of the ball broke off and was lodged partway through the track.

Booth then slashed Major Rathbone, who had replaced General Grant as the invited guest of the evening, and climbed backwards over the edge of the box, catching one spur on a picture and in a Treasury Department flag which draped the front of the box. He was thrown off balance and landed heavily on his left foot, apparently breaking his fibula just above the ankle, but making his laborious escape via a horse which he had left tethered outside the back door of the theatre.

An Army surgeon, Dr. Leale, from the audience, was the first physician into the box after Major Rathbone had loosened Booth's barricading bar at the door of the Box. He found Lincoln comatose and could not discern respirations or pulse. He applied mouth to mouth respiration and straddled the chest to give closed chest "artificial respiration" (but pressing upwards to stimulate the heart). Pulse and respiration were restored and the patient even appeared to swallow one teaspoonful of diluted brandy, but thereafter would not swallow. It was thought too risky to move Lincoln to the White House, so he was then moved to a bed in a rooming house across from the theatre by a multiple hand-carry.

One pupil was widely dilated from the start, with the other pupil contracted at first, but both were unresponsive to light. About 1 a.m. both pupils became widely dilated and fixed, and stayed that way thereafter. (Conflicting statements were recorded as to which pupil was contracted at first.) The pulse was abnormally slow (40) except for a convulsive episode about 1 a.m., at which time it rose to 100 for a short period. Whenever the drainage of blood, fluid and brain tissue from the wound would slow, the respirations would become labored, but would improve when

the coagulum was removed. Respirations become progressively more labored and intermittent until they ceased (some nine hours after the shooting) at 7:21 and 55 seconds a.m., and pulse became imperceptible at 7:22 and 10 seconds a.m.

Five hours after death, an autopsy was performed at the White House, and only the cranium was opened. The bullet was found to have torn across the left lateral venous sinus, and traveled through the brain for a distance of seven and one-half inches, inflicting extensive damage along its track which was clearly visible through the hemorrhagic and "pultaceous" brain substance. There appears little room for any possibility that Lincoln might have survived, because of the contamination of the wound with multiple foreign bodies, probable hair, skin and possible fragments of greased patch or paper wadding which accompanied the bullet within the brain, the probing by unsterile fingers and probes, and the probability that a large soft tissue cavity had formed within the brain at the moment of impact.

Could Lincoln Have Survived?

Could modern neuro-surgical techniques, blood transfusions, supportive and anti-bacterial therapy have made it possible for Lincoln to have survived, had he been shot in 1964, 99 years later, instead of 1865?

Many competent authorities have expressed themselves without reservation⁷ that Lincoln could not possibly have survived. The large projectile, striking the head with the force of a sledge hammer had driven a disc of bone almost one inch in diameter ahead of it through the lateral venous sinus, across the meninges, and into the brain to a depth of three inches. A fragment of metal the size of a modern dime had torn off and was left in the track, and the balance of the projectile had travelled a distance of seven and one-half inches through the brain to lodge almost at the other side of the skull. The combination of foreign material scattered in a track through the center of the brain would have been impossible to locate and clean out, as any experienced wartime surgeon knows.

In addition, the brain had been probed to the full length of the unsterile fingers of at least two of the doctors who attended him, in an attempt to locate the ball, and

with two unsterile probes, a silver one approximately six inches long, and a porcelain tipped rubber "Nelaton" probe, to a distance of seven and one-half inches. The principles of aseptic technique, and indeed the knowledge of germs as the cause of wound infections were unknown in Lincoln's day, and while occasional Civil War soldiers were reported to have recovered from bullet wounds of the brain, these were obviously very rare exceptions.

The autopsy report that the track of the bullet could be easily distinguished because of the extensive destruction and the presence of pultaceous brain material along the track points up the tremendous damage, but does not take into account the further damage which is now known to result from the momentary creation of a large cavity in the brain,⁸ when it is struck by a missile traveling at the speed of a bullet. There seems to be no reason to disagree with those who have stated that Lincoln could not possibly have survived this wound, even in modern times, and that, indeed, it is remarkable that he survived for about nine hours. Even if he had survived, he most certainly would have been a decerebrate "vegetable," a cruel transformation from the sensitive, compassionate and thoughtful Chief of State, which he had been. Death probably spared him a vicious campaign of character assassination and defamation which would have accompanied his avowed attempts to curb post-war profiteering, exploitation and vengeance directed at the prostrate South. As it was, assassination at the very peak of his popularity, enshrined him forever in the history of the world. ◀

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Surgeon General's Office
Washington City, D.C.
April 15th, 1865
Brigadier General J. K. Barnes
Surgeon General U.S.A.
General:

I have the honor to report that in obedience to your orders and aided by Assistant Surgeon E. Curtis, U.S.A., I made in your presence at 12 o'clock this morning an autopsy on the body of President Abraham Lincoln, with the following results. "The eyelids and surrounding parts of the face were greatly echymosed and the eyes somewhat protuberant from effusion of blood into the orbits.

There was a gunshot wound of the head around which the scalp was greatly thickened by hemorrhage into its tissues. The ball entered through the occipital bone about one inch to the left of the median line and just above the left lateral sinus, which it opened. It then penetrated the dura mater, passed through the left posterior lobe of the cerebrum, entered the left lateral ventricle and lodged in the white matter of the cerebrum just above the anterior portion of the left corpus striatum, where it was found.

The wound in the occipital bone was quite smooth, circular in shape, with bevelled edges. The opening through the internal table being larger than that through the external table. The track of the ball was full of clotted blood and contained several little fragments of bone with a small piece of the ball near its external orifice. The brain around the track was pultaceous and livid from capillary hemorrhage into its substance. The ventricles of the brain were full of clotted blood. A thick clot beneath the dura mater coated the right cerebral lobe.

There was a smaller clot under the dura mater of the left side. But little blood was found at the base of the brain. Both the orbital plates of the frontal bone were fractured and the fragments pushed upwards towards the brain. The dura mater over these fractures was uninjured. The orbits were gorged with blood. I have the honor of being very respectfully your obedient servant.

E. J. J. Woodward
Assistant Surgeon
U.S.A.

How Federal Pay is Growing

Any wage gap between federal employees and those in private industry is now in favor of government workers. Commerce Department figures show that last year the annual average earnings of full-time government workers reached \$7,131, \$70 more than those of private industry employees, and an increase of \$1,155 over three years.

Fibromas (fibromatoses) represent a comparatively rare tumor of omentum and mesentery. A fairly recent review of the literature¹ listed 35 acceptable case reports and added 12 new observations. Three additional cases have been reported since.^{2,3,4}

A giant fibroma of the mesentery was observed recently in this institution, its presence being recognized after the termination of a normal pregnancy.

Giant fibroma (Fibromatosis) Of mesentery

BY HENRY P. LATTUADA, M.D., MARIO STEFANINI, M.D.,
AND LEWIS C. POWELL, M.D.,/DANVILLE

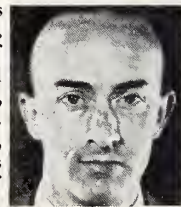
Case Report

A 23-year-old woman was admitted on July 27, 1968, during her seventh month of pregnancy, complaining of cramping pain in the right flank and upper abdomen. Two previous pregnancies had terminated in normal full-term deliveries. She was not in labor. Abdominal examination revealed that the baby was in the vertex position. The fetal head was not engaged and the fetal heart tones were audible. No other intra-abdominal enlargement except the pregnant uterus was discernible. Flat plate of the abdomen, gall bladder series and IVP indicated a pregnant uterus along with a non-functioning gall bladder and a normal urinary tract. A diagnosis of false labor was made and the patient was discharged. She was seen twice in the office complain-

ing only of pressure and discomfort in the right side of the abdomen. On September 29, 1968, the patient returned to the hospital with a similar complaint. Six days later she delivered spontaneously and uneventfully a normal living female infant weighing 3,820 gms. The palpation of the abdomen, after delivery, revealed a large, lobulated, firm, movable mass to the right of and higher than the uterus, extending toward the flank. A diagnosis of retroperitoneal tumor or of large ovarian cyst was made. Repeated X-ray studies showed cholelithiasis in a normally functioning gall bladder and a large intra-abdominal mass displacing loops of bowel and causing intrinsic pressure on the right ureter. Routine laboratory studies were within normal limits.



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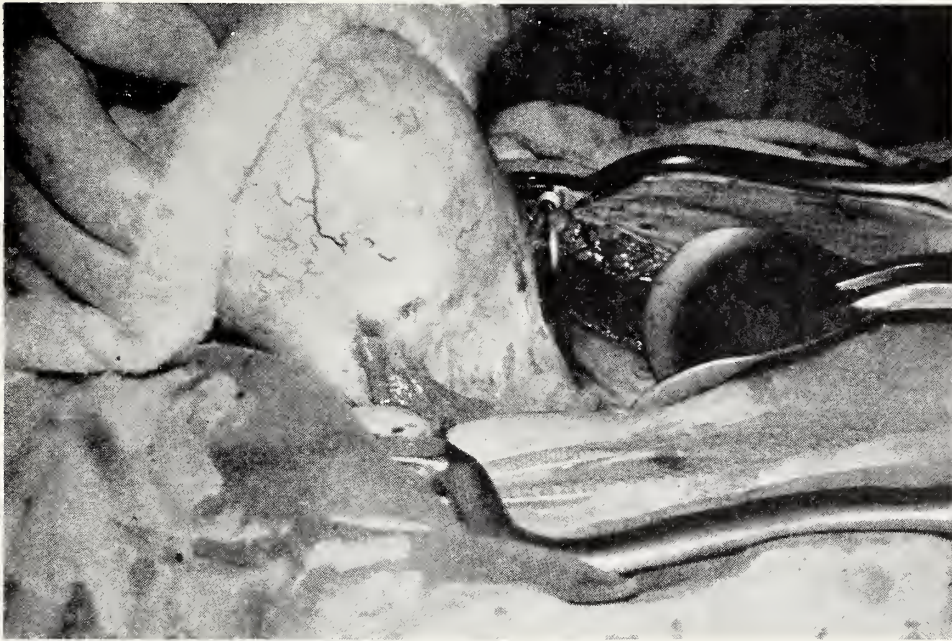


Fig. 1. Fibromatosis (giant fibroma) of mesentery at surgery.
(A) anterior view (B) lateral view.

Surgery was carried out on October 14, 1968. At laparotomy under 2-bromo-2 chloro-1,1,1 trifluoro-ethane (halothane) anesthesia, the involuting uterus, Fallopian tubes and ovaries were identified. A large, irregular, smooth, solid tumor occupied the space between the leaves of the mesentery

of the terminal ileum and ascending colon (Fig. 1, a & b). The appendix was stretched over the surface of the tumor. This was delivered from the abdomen, together with tightly adherent portions of the terminal ileum and ascending colon, and mobilized after ligating its blood supply which was

represented by branches of the ileo-colic artery. Small bowel and inferior aspect of the cecum were separated from the tumor, while the appendix was removed with it. As the blood supply to the cecal area had been likely compromised, the distal por-

Microscopic sections of the tumor (Fig. 3) showed a collagenous stroma arranged in broad, interlacing, strap-like bands of intensely acidophilic material and in bundles running in various directions. There were areas of necrobiosis resulting in cyst for-

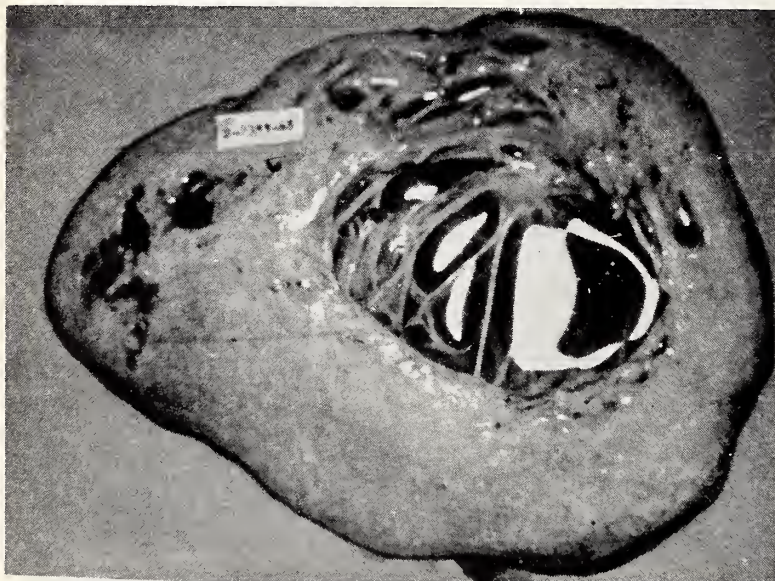


Fig. 2. Fibromatosis (giant fibroma) of mesentery. Appearance of surface section of tumor. (See text.)

tion of the ileum and of the proximal ascending colon were removed, this step being followed by end-to-end anastomosis between cecum and ascending colon. The patient made an uneventful recovery. There is no recurrence of tumor one year later.

Pathologic findings

The specimen consisted of a large, hard, yellowish mass, weighing 1,030 gms. and measuring 21x16x12 cm. A few superficial cystic bosselations were present, umbilicated centrally, measuring up to 1.5x1 cm. The appendix vermiformis, 9 cm. long, was attached to the mass through fibrous bands. On section, the tumor appeared firm, fibrous and gritty. The cut surface oozed a small volume of clear fluid. There were irregularly branching and fibrous trabeculae, opaque and greyish-white. Many intervening areas were translucent, pale and tannish-grey, almost myxomatous in appearance. In the center of the mass was a cystic cavity, measuring 8x6.5x6 cm., containing yellowish, serous fluid, and surrounded by numerous smaller cavities (Fig. 2). Also received were 15 cm. of ileum and 16 cm. of colon, showing dusky wall.

mation and hyaline transformation of collagen was frequent. Many areas showed few benign appearing spindle cells. The blood vessels scattered through the lesion were unremarkable. The portions of ileum and of ascending colon showed congestion of vessels.

Comment

Benign tumors of the mesentery, and fibromatoses among them, do not present characteristic clinical findings. They are asymptomatic in the early stages, and when



Fig. 3. Microscopic section of tumor (H & E). Note the collagenous stroma arranged in bundles running in various directions and separating benign appearing spindle cells.

discovered, they usually measure between 10 and 20 cm. in diameter. Then, signs of mechanical compression begin to appear (vague pain and abdominal discomfort, constipation, frequency, nausea and vomiting) as well as unexplained loss of weight. X-ray findings are for the most part equivocal, indicating displacement of the bowel without intrinsic distortion. These large tumors infiltrate the leaves of the mesentery and serosa of bowel. Thus, because of adherence to the bowel and the likelihood of recurrence after incomplete excision,^{1,2} the entire tumoral mass must be excised and portions of small and large intestine are likely to be sacrificed as well.

Our patient is apparently the first case in which a giant fibroma was associated with pregnancy. Thus, the vague symptoms which could have drawn attention to the tumor were attributed to pregnancy. Because of the frequent association of fibromatoses with Gardner-Stephens' syndrome,⁵ evidence of intestinal polyposis, epidermoid cysts, leiomyomas or bone tumors was sought in the patient and her relatives, without success. There was no familial history of carcinoma of the gastro-intestinal

tract. Thus, this case represents another instance of idiopathic fibromatosis of the mesentery. Its rarity and its association with pregnancy warrant this report.

Abstract

A case of giant fibroma (fibromatosis) of the mesentery was discovered at exploratory laparotomy in a patient who had delivered recently. The tumor was excised, along with adjacent portions of ileum and of ascending colon. There was no evidence of concurrent Gardner-Stephens' syndrome. There has been no demonstrable recurrence of the tumor within one year. ◀

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School physician does as told

The fact that the school physician apparently does as he is told may help explain the fact that he is, in general, satisfied with his job (as reported in a study on attitudes of these same school physicians toward their work). This may be so in spite of the fact that he also feels that the current school health program is not meeting what he feels are the most important health needs of the children in these schools. Apparently, the physician working in a large school district carries out specific duties as directed by others in the system—no matter what his own personal characteristics are, what his professional training has been, or what his attitudes and beliefs are concerning the health needs of school-age children.

What are the implications of these findings? If physicians are willing to do as they are told when working in a large health system, it does not seem reasonable to suppose that changes in the curriculum in medical schools or in the postgraduate training programs will influence the activities of these same physicians in large health programs. It appears, rather, that any needed changes must come from the leaders of large health services where the decisions are made concerning administrative recommendations for physician activities. The importance of the quality of personnel in the positions of leadership in health service programs would appear to be great in view of the findings. With the urgent physician manpower shortage and with the large number of physicians spending thousands of man-hours in our schools, it seems imperative that a new, long, hard, realistic look be given to what school physicians are being told to do. (Marsden C. Wagner et al.: A Study of the Determinants of School Physician Behavior. *American Journal of Public Health* 60:8, (Aug.) 1970, pages 1435-1438.)

Pathology of Ocular trauma

BY MILTON M. SCHEFFLER, M.D./ CHICAGO

The material to be presented deals with eyes enucleated because of severe trauma, mechanical in character, which resulted in complete disarrangement of the visual apparatus. The type of injury was of two major varieties; penetrating; and non-penetrating, the latter that of blunt trauma.

The following three topics will be discussed:

1. Retained Foreign Bodies
2. Epithelial Implants and Down Growth
3. Blunt Trauma

Retained foreign bodies

Cilia: These will frequently be seen within the globe following injuries by glass or sharp objects affecting the lid borders. When in the cornea, they may often be the cause of a fistulizing wound and poor healing.

Case 51-39: A corneo-scleral laceration resulted in an iris prolapse and vitreous loss. On microscopic exam, the cause of the faulty wound closure and partial epithelial down growth was seen to be a retained cilia in the wound.

Case 52-2: A fistulizing wound of the cornea following trauma, necessitated a corneal transplant. Microscopically, a cilia was found as the cause of the failure of the cornea to heal.

Frequently, an unsuspecting foreign body is found on microscopic examination, because enucleation was indicated in an eye responding poorly to therapy.

Case 49-12: A corneal laceration occurred from the broken end of a venetian blind. There was iris and lens prolapse with an anterior chamber hemorrhage. Because the eye did poorly, enucleation became necessary at the end of six weeks. Microscopically, a retained piece of wood was seen embedded in the posterior sclera, having penetrated the retina and choroid. A foreign body reaction about the retained substance was quite prominent, consisting of giant cells and epitheloid cells. The edema and infiltration of the nerve head were indicative of an optic neuritis.

The retention of metal following a penetrating injury can ultimately result in loss of the eye because of the toxic products produced. When a penetrating injury is suspected or visualized, an X-ray of the eye and orbit is essential and of medico-legal importance. If the object is radio-opaque, and retained in the globe, its pres-

ence can be visualized readily and steps taken for its removal. Accurate localization is very important to facilitate removal of the foreign body without further trauma to the vital ocular structures.

Case 48-36: The microscopic picture of Siderosis of the bulb was produced from an unsuspecting retained metal foreign body. The injury occurred approximately one year ago while the patient was working with a hammer and chisel. At the time of the enucleation, the eye was blind. The anterior chamber was very shallow due to the forward displacement of the iris-lens diaphragm from a swollen cataractous lens, with a brownish discoloration. The appearance suggested a Siderosis of the bulb, and an X-ray revealed the presence of the foreign body.

Microscopically it is noted that the dissolved iron compound is absorbed by the epithelial structures of the globe, the dilator and sphincter of the iris, the epithelium of the lens, the non-pigmented epithelium of the ciliary body and the retina.

The presence of the diffusible iron compound first results in an irritative phenomena, followed by destruction of the visual apparatus.

Case 55-37: A penetrating foreign body was visualized by X-ray just below the horizontal plane, temporally, and 8 mm behind the center of the cornea. Some eight days later an attempt was made, unsuccessfully, to remove the foreign body, by way of a posterior sclerotomy incision. Eight days after surgery, the eye was enucleated. There was a partial hyphema and an opaque lense.

Microscopically, the cornea is blood-stained and a healing corneal perforation is visualized with the iris adherent to the posterior corneal surface. The wound is seen to traverse the ciliary body, indicating the path of the foreign body with injury to the nasal equator of the lens. The foreign body was ultimately seen in the posterior pole of the eye, surrounded by a localized abscess in the vitreous. The site of the posterior sclerotomy wound remained unhealed. Healing of scleral wounds are the result of proliferation of the episcleral as well as the suprachoroidal tissue, since the sclera itself is inert.

The very early removal of intra-ocular foreign bodies is essential to the survival

of the visual function. The site for its removal should allow for a minimum of trauma to an already traumatized eye.

Epitheleal downgrowth and implantation cysts

This group of cases is characterized by the presence of epithelium within the ocular structure, resulting as a rule from poor or delayed wound closure, or the implantation of epithelium following a penetrating injury.

Epithelial downgrowth

The essential feature is a poorly closed wound, whether it be due to incarcerated tissue such as iris, lens or vitreous, or poor apposition of the wound lips, whatever the cause. The surface epithelium grows down between the wound lips into the anterior chamber, where it will ultimately line the posterior corneal surface, the angle and cover the anterior iris surface. In the presence of a vascular supply, it will grow luxuriously over the iris surface, but remain thin on the posterior cornea.

Its presence will be manifested by a greyish veil on the posterior cornea, progressing, associated with an irritable eye and ultimately a secondary glaucoma, which does not respond to therapy.

Case 62-13: A corneo-scleral laceration was repaired, followed by an irritable eye. Epithelial cysts were ultimately seen in the anterior chamber. Microscopically, a gaping, healed corneo-scleral wound is noted, lined by epithelium, which is seen to extend throughout the anterior and posterior chamber. The iris is heavily infiltrated with plasma cells.

Case 55-101: The case presented with a secondary glaucoma and a dark area in the inferior temporal sector which suggested a possible tumor. Microscopically, an unusual epithelial downgrowth was demonstrated. It extended from the lips of the scleral wound, the site of the dark mass, extending forward in the supra choroid, lamina fusca of the ciliary body and into the anterior chamber.

There was no history of trauma or a surgical procedure, yet the nature of the course of the epithelium suggested a cyclo-dialysis.

Epithelial implantation cysts

These result from the implantation of epidermal cells or surface epithelium following a penetrating injury. The epidermis about the lashes is a common offender. The epithelium thus implanted, may grow as a solid tumor to form the Pearl Cysts or with central liquifaction, form a translucent cyst, lined by epithelium.

Case 52-3: The eye had been injured at the age of 12 years. Now at the age of 74, the eye was painful, red, with considerable tearing. There was an elevated, protrusion of the cornea, 5 mm in diameter, which on slit lamp was due to an ectasia of the anterior corneal layers. Microscopically, there was a central edematous fibrous tissue containing an epithelial lined cyst.

Case 68-8: Following a penetrating injury, a small epithelial plug is seen implanted in the iris. This illustrates the onlage of the implantation pearl cyst.

Case 52-57: At the age of 17 years, a dark mass was noted on the iris. A prophylactic iridectomy revealed a large implantation cyst. The history of trauma was quite obscure.

Case 61-11: This child suffered a penetrating wound about the lower limbal area, successfully repaired. He subsequently returned with a visible large cyst inferiorly in the anterior chamber. A diagnosis of an iris implantation cyst was confirmed microscopically, following an iridectomy at the site of the cyst.

Case 49-8: There had been periodic attacks of pain in the eye following a penetrating injury some 27 years ago. The attacks became quite severe prior to enucleation with the clinical picture of an acute secondary glaucoma. Microscopically, a solid epithelial plug fills the iris.

Case 54-77: This most unusual case occurred in a 4-year-old with no previous history of trauma. A grey area was first noted in the cornea with a visual acuity of 20/20. The opacity progressed over a period of years until the entire central area was involved. The clinical diagnosis was a lipoid dystrophy or possible dermoid. At the time of the penetrating corneal transplant, as

the cornea was cut, a milky fluid escaped. The microscopic picture was most enlightening. There were two corneal layers, lined on its adjoining surfaces by a layer of epithelium. The deep corneal stroma was heavily scarred and vascularized. The diagnosis was an intracorneal epithelial implantation cyst.

Non-penetrating injuries—blunt trauma

Blunt trauma to the globe, insufficient to cause rupture of the ocular coats, may still cause considerable damage. The pathology visible will vary, and is dependent upon: 1) damage to the cells causing a disturbance in physiologic activity; 2) the degree of vascular reaction; 3) mechanical trauma to the tissue. Rupture and displacement of the uveal tract, lens, retina and optic nerve may result.

HypHEMA, the result of injury to the ciliary body or iris, if associated with a prolonged secondary glaucoma, may result in blood staining the cornea. This may occur even in soft eyes, if the endothelial cells have been damaged. Iris contusions may result in a variety of finding. The trauma initially produces a marked edema followed by subsequent necrosis, especially with an elevated pressure.

Case 55-14: Illustrates the picture of blood staining from prolonged hypHEMA as well as a developing iris necrosis in a hypertensive globe.

Ruptures of the iris at its insertion in the ciliary body, iridodialysis, is a frequent cause of a severe anterior chamber hemorrhage and subsequent secondary glaucoma. This is well demonstrated in *Case 49-71*.

Traumatic cyclo-dialysis, a tear thru the scleral spur, with separation of the ciliary body, will also cause considerable hemorrhage. *Case 49-56*, not only reveals this, but also a posterior scleral rupture.

A more serious affliction is a tear thru the anterior surface of the ciliary body into the stroma, resulting in a deepening of the anterior chamber and the development of a glaucoma at a later date which responds poorly to therapy. The immediate effect is a severe hemorrhage, due to damage to the major circle of the iris.

Case 62-81: This eye suffered blunt trauma in childhood and now at the age of 56, there had been progressive visual loss for the past five years. The eye prior to

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enucleated was red, painful and hard. The microscopic picture is typical of the angle recession glaucoma, with the trabecular area and tear covered by a new formed Descemet's membrane.

Case 49-59: This was the eye of a boxer who had repeated blunt trauma to the eye. The presence of a dislocated lens, secondary glaucoma, and multiple organized subretinal hemorrhages with destruction of the rods and cones is a mute testimony to the hazards of this occupation.

Case 51-31: Blunt trauma resulted in an "eight ball" hyphema with secondary glaucoma and blood staining of the cornea. Treatment was refused and when the eye was enucleated one year later, there was corneal scarring, necrosis and scar tissue replacement of the ciliary body with an intercalary staphyloma on the opposite side.

Case 54-16: Blunt trauma occurred in May and when examined in July, there was evidence of a detached retina with tears and retinal hemorrhage. In October, the uninvolved eye revealed a mild anterior and posterior uveitis. The microscopic picture of the enucleated traumatized eye revealed a healed choroidal rupture without evidence of interruption of the scleral continuity and a granulomatous choroidal nodule histologically resembling sympathetic ophthalmia. This later finding is rather unusual.

In this last group of cases, the blunt trauma was of sufficient force to result in rupture of the globe. This usually occurs at the site of the trauma, but more often at an anatomically weak site, anteriorly, in the vicinity of Schlemm's canal, and frequently associated with dislocation and loss of the lens through the tear; about the thin equator or site of the exit of the vortex veins, and posteriorly, in the vicinity of the perforating short ciliary vessels.

The diagnostic phenomena of an exceedingly low tension is significant in posterior ruptures. Massive intra-ocular hemorrhage is usually an accompanying finding of the ruptured globe.

Case 49-74: Rupture in the vicinity of Schlemm's canal with loss of lens and prolapse of iris and ciliary processes with massive anterior chamber hemorrhage.

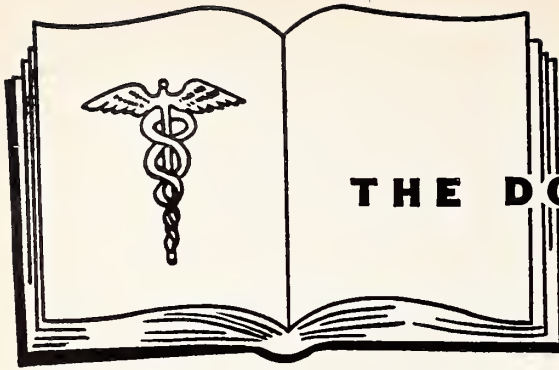
Case 49-70: Scleral rupture over the pars plana with prolapse of ciliary body, retina and vitreous. A deep anterior chamber is evident. The healing of scleral ruptures is facilitated by the proliferation of the fibroblasts from the episcleral and suprachoroidal tissue, with the sclera itself inert.

Case 50-7: Reveals posterior scleral rupture, associated with a soft eye and marked hyphema. ◀

Is autopsy obsolete?

The autopsy, the oldest method of medical investigation, has been placed in a peculiar position. To some it is now an unnecessary procedure, one that has been superseded in importance by newer methods of study, biochemistry, cardiac catheterization, angiography and isotope scanning, to mention a few. The more enlightened who hold this view will admit that the foundation upon which we draw conclusions from the newer tests are based upon correlations with autopsies. They argue now that since the anatomic baselines have been established, we should "move on" in the newer fields.

The clinician disenchanted with autopsies will complain that the pathologist fails to give him concrete answers to his questions. At times the pathologist's service to the clinician and to the case would be improved were the pathologist better oriented as to the basic principles of the disease states with which he works. Pathology is in a way a facet of clinical medicine and the clinically oriented pathologist can serve better than the one who considers pathology a field complete unto itself. While there is room for improvement in the technique of the autopsy, there is no justification for elimination of it. (Jesse E. Edwards.: *The Autopsy: Do We Still Need It?* *Chest* (Editorials) 57:2 (Feb.) 1970, pages 113-114.)



THE DOCTOR'S LIBRARY

THE ACUTE ABDOMEN. By Thomas W. Botsford, M.D. and Richard E. Wilson, M.D. W. B. Saunders Company, Philadelphia, 1969.

Drs. Botsford and Wilson have uniquely organized this new book, not by organ system or anatomic location but rather by basic pathophysiologic processes. In considering such diseases as acute appendicitis, acute cholecystitis and acute diverticulitis together as "Acute Abdominal Inflammatory Disease," the unifying concept of pathogenesis becomes immediately apparent. Rather than learning about several separate diseases, the reader is presented with a common pattern of disease which can affect several organs, producing the identical signs and symptoms of the acute abdomen. This approach is continued in the sections on abdominal trauma, intestinal obstruction, intra-abdominal hemorrhage.

In a separate section, the tools used in diagnosis are discussed. Accurate communication between the physician and patient is properly stressed but poorly illustrated. For example, the authors suggest that, rather than ask a patient if his pain comes and goes, the physician should ask if the pain is colicky or crampy. Unfortunately, many patients may be unable to correctly define colicky pain and furthermore might be embarrassed to ask for a correct definition. Similarly, the authors suggest asking the patient, "How is the pain affecting you?" This reviewer would be at a loss to answer this question and certainly would not

respond with statements about his appetite or bowel movements.

In addition to the routine laboratory and X-ray examinations, some newer and more specialized diagnostic techniques such as angiography and radioactive scanning are described. Although the indications for using these techniques are mentioned, they are not complete. Thus, the authors suggest the use of angiography in diagnosing renal trauma while failing to mention its value in diagnosing fractures of the liver or subcapsular splenic injuries.

Many of the discussions are not complete. At times, only one side of a controversial subject is presented. For example, the use of a barium meal in small bowel obstruction is described as a safe procedure which should be used to confirm the diagnosis and ascertain the level of the obstruction. Similarly, the only treatment suggested for right colon wounds is the right hemicolectomy with proximal enterostomy. In some instances, such as upper gastrointestinal bleeding or large bowel obstruction, treatment is not discussed at all. While it is probably beyond the scope of this short book to completely consider treatment, it is disconcerting to have treatment discussed for some diseases and omitted for others.

The novel approach used in considering the diseases which cause an acute abdomen is excellent. Unfortunately, the authors have severely limited their discussions, omitting important aspects. A lack of thoroughness seriously detracts from the value of this new book.

Stuart M. Poticha, M.D.

Taxes may outstrip wage increases

Taxes could rise faster than wage increases this decade, a Chamber of Commerce of the United States study predicts. A family of four whose earnings may go from \$10,000 to \$16,000 can expect taxes to double, largely because of growing expenditures by state and local governments.

Medical care of the elderly patient

BY BERTRAM B. MOSS, M.D./CHICAGO

The medical care of the aged individual is not basically different from medical care for adults. There are however certain emergencies that seem to be more common among the aged and there are also some specific pitfalls and dangers inherent in dealing with problems of the aged. The elderly patient usually has a multiplicity of diagnoses. He may have had long-standing chronic complaints from all of these illnesses, but for some reason the balance is suddenly tipped and there is an acute disruption with a resultant emergency. The patient may have been chronically decompensated or suffering from a chronic bronchitis but an acute super-imposed infection may precipitate a pneumonitis. We constantly implore elderly persons to establish with their doctors previous base line statistics for their physical condition. They should have periodic electrocardiograms and chest X-rays, so that if there is some acute illness we then have something to compare with prior conditions and status.

Many illnesses cause violent symptoms in younger persons, but not in the elderly. A common example of this is with bronchopneumonia. Acute abdominal ailments can also be deceiving. Oldsters often do not feel the pain or they are so used to having chronic pains, they do not realize or report an acute situation. It is not uncommon for an elderly person not to complain about the pain of a recent myocardial infarction for the same reasons. They may not feel the pain as much because over the years, collateral arteries have developed and when one branch occludes, others take its place.

On the other hand, a person of any age will succumb if a major artery is blocked. A somewhat similar situation exists relative to hypertension. The few oldsters who have hypertension usually can live a comfortable but mildly restricted life.

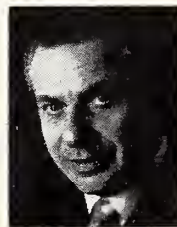
We have to be aware of what may have precipitated any fall which produces a fracture or injury. There may have been a "little stroke" or just a sudden weakness, dizziness, loss of sight or temporary hearing, or even confusion, which resulted in the presenting trauma. The emergency may have been precipitated by a special drug effect or by an inter-potential of many drugs.

Those who deal with medical problems of the elderly must be aware of the "normal abnormalities" of aged persons. It is not presumptive of diabetes to have only one elevated fasting blood sugar in an elderly person. A blood urea nitrogen may be "normally" elevated in an elderly person.

Dizziness

Elderly people are particularly prone to present with just "symptoms." One of the most distressing is the complaint of dizziness. Cardiac arrhythmias in elderly persons can bring on episodic cerebrovascular insufficiency. Simple dizziness requires examination of the eyes, the proprioceptive system, and the central nervous system. Whirling vertigo requires examination of the ears, eighth nerve and even brain stem. The emergency care of the patient with dizziness also requires that we rule out anemia,

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blood pressure disturbances, and acute cardiac pathology. Drugs and chemicals such as quinine, arsenic, mercury, lead, aspirins, sulphonamide and alcohol may also produce dizziness. Some cases of dizziness have been relieved by a procedure as simple as the removal of impacted wax in the ear. We think of Menieres disease when the dizziness is accompanied with impaired hearing, unbearable nausea and severe vomiting.

Primary glaucoma of the elderly can be a problem. Careful attention should be paid to a history of halos or recurrent discomfort particularly in the eye, as during a movie. During the acute congestive glaucoma phase, there is a severe ocular pain and blurring of vision. Nausea and vomiting may be so severe, especially in elderly people, that one often does not think of glaucoma and often mistakenly treats for gastrointestinal difficulty. If a tonometer is not immediately available, palpation of the eyeball itself, through closed lids, will usually reveal a very hard eye. Surgery is usually imminent in acute glaucoma but prior to this, miotic therapy, intravenous carbonic anhydrase inhibitors and hypertonic agents such as urea are very effective. Vision lost from uncontrolled glaucoma can never be regained. Experience in the use of a tonometer is highly recommended.

Arthritis

An elderly woman presenting with acute pain in the knee, hip, ankle, sacroiliac or subtalar joints should alert one to suspect a diagnosis of septic arthritis. This should particularly be considered if an elderly person is anemic and has an elevated sedimentation rate. It should even be more suspicious when the leading predisposing factors for bacterial arthritis are present, such as the use of systemic corticosteroid administration, pre-existing infection and diabetes mellitus. Other frequent local pre-disposing factors are prior intra-articular injection of corticosteroids and pre-existing joint disease.

Elderly women with diffuse musculoskeletal pain, but not detectable changes in the muscles and joints, should make one suspicious of polymyalgia rheumatica. To confirm the diagnosis, it is necessary to have a high erythrocyte sedimentation rate associated with an elevation of alpha-globulins.

Headaches with these symptoms should make one suspicious for giant cell arteritis. Irreversible blindness due to temporal arteritis can be prevented with prompt and judicious use of steroids. Don't forget about gout causing a sudden joint pain—especially if the patient is taking diuretics and the pain becomes worse with use of aspirin. An elderly person with sudden edema may have grave implications. Basically all edema is renal in origin. The kidneys reabsorb sodium or there are not enough functioning nephrons to eliminate sodium. The Nephrotic syndrome produces edema by causing hypoalbuminemia through renal protein loss. There are certain drugs which cause edema and these include both synthetic and natural conjugated estrogens, some steroids, phenylbutazone, oxyphenylbutazone and guanethidine.

Acute edema

With elderly people we should be particularly aware of the mechanism of generalized acute edema. Blood clots, paralysis, injuries and burns, lymphatic obstruction, allergies and reactions to heat and cold can result in edema. Lack of muscular tone in stroke patients leads to edema. A patient may have pulmonary edema without evidencing edema elsewhere. Dyspnea, orthopnea and nocturnal dysuria suggest a cardiac basis for the edema. It is necessary to check for the typical pitting edema due to hepatic, cardiovascular and renal disorders. Edema with a pigskin appearing brawny picture suggests lymphatic obstruction. Thrombophlebitis and pelvic tumors may produce sudden edema. Easily visible neck veins of a patient at a 45° angle suggest cardiac failure. Hypertension may be absent in idiopathic nephrotic syndrome but present in acute glomerulonephritis with edema. Emergency laboratory tests will show a white count indicating an inflammatory disease or endocarditis. It may be necessary to do liver function tests, chest X-rays, or an electrocardiograph. The central venous pressure should be watched by elevating the patient's bed and noting whether his neck veins are still visible. I doubt whether central venous pressure catheterization will always be necessary. We have to be cautious about diagnosing cardiac failure because a patient with glomerulonephritis may have increased venous pressure without heart failure.

The most serious edema is the acute pulmonary edema. Most edemas are harmless and the vast majority of edematous patients should not be hurriedly treated without an established diagnosis as to the cause. But the patient with acute pulmonary edema, must be treated immediately. This patient should be put into a sitting position. We immediately increase the concentration of oxygen that the patient is inspiring (usually under positive pressure) and increase the transfer of oxygen across the alveolar membrane by adding 30% to 50% alcohol to the nebulizer of the positive pressure breathing unit. We should immediately digitalize the patient but remember that it may take several hours for the drug to become maximally effective. It may be necessary to apply tourniquets to increase the venous return to the right side of the heart thereby decompressing the pulmonary vascular bed. Some authorities would rather do a phlebotomy than apply tourniquets. After this is done, a rapid acting diuretic should be given intravenously. If morphine is given, keep the dose low, because the pickup is slow and it accumulates. If the patient has a bradycardia, we substitute demerol for morphine or use atropine along with the morphine.

Effects of digitalis

Too many old people are taking digitalis when they should not, or they are taking too much of it. Digitalis has so many toxic potentials that I suspect it would have a difficult time passing FDA regulations today. It's a wonderful drug but we lack definitive yardsticks to evaluate its dosage, and the margin between therapeutic and toxic doses is very narrow. Acutely ill elderly patients on diuretics plus digitalis, especially those with advanced heart disease, liver disease or renal insufficiency should be considered as potentially digitalis intoxicated. Don't rely on the usual dosage range. Be suspicious if the patient on digitalis has anorexia. Order an EKG immediately. Digitalis intoxication frequently presents with gastrointestinal signs such as anorexia, nausea, vomiting and rarely diarrhea. Palpitations, blurred or yellow vision and all kinds of arrhythmias are frequent complaints. On the basis of suspicion alone, I advise to stop digitalis and start potassium, orally or intravenously. Dilantin,

pronestyl, xylocaine or quinidine may also be used in acute cases. I am not yet thoroughly convinced about the usefulness of Beta adrenergic receptor blockers. When the patient has significant AV block, unassociated with atrial tachycardia, **DON'T GIVE POTASSIUM!**

A sudden exacerbation of the usual complaint of feeling weak or fatigued should be respected. Nearly all muscle weakness will respond to conservative therapy. However, after two or three days if there is the beginning of real diminution of reflexes, the patient must be hospitalized and prepared for possible intubation or tracheostomy. When the onset of weakness is sudden, we must suspect viral infections, functional weakness, myasthenia gravis, multiple sclerosis, periodic familial paralysis and diabetes, or sudden loss of potassium. With severe headache and true stiffness of the neck we hospitalize the elderly patient for a spinal tap. Double vision is the commonest early symptom of myasthenia gravis, accompanied by weakness. Another cause of sudden weakness in older patients is a transient ischemic attack.

It is not uncommon for geriatric patients to present with a sore mouth and dryness of the mouth and tongue which has been going on for some time but suddenly becomes unbearable. There are many causes of this distressing condition and many more that are not so easily diagnosed. Because of the dryness the patient has discomfort, anxiety and difficulty in swallowing. In the absence of specific diagnosis and treatment a symptomatic approach would be to rinse the mouth with Karo syrup in warm water, or glycerine and lemon juice in water before meals. Salivary secretion, if the mouth is found to be too dry, can be stimulated by physostigmine, neostigmine or pilocarpine.

Elderly people often present themselves with acute pain in the back or upper leg. A common cause of "sciatica" is protruding or slipped disc between the vertebra of the lower back. Excruciating pain upon movement of a joint could be due to a tendonitis or bursitis. The fat embolism syndrome can occur in elderly people usually within 48 hours after a fracture. The clinical signs associated with the fat embolism syndrome are an elevation of temperature, a tachy-

cardia and a rapid respiratory rate. There could also be an extensor posturing and decerebrate rigidity. Petechiae are often visible. If the diagnosis is suspected, serial examinations for fat in the urine and serum lipase should be done immediately. A chest X-ray may demonstrate the typical "snow storm appearance."

Patients coming to the emergency room with the suspicion of a stroke should be hospitalized. It is particularly important to determine whether the manifestations that appear are due to a carotid circulatory insufficiency or a vertebrobasilar insufficiency.

If the diagnosis of an elderly person's bizarre complaints or behavior is not clear, all efforts should be made to determine what drugs and what amount of drugs are used. The incidence of adverse reactions when patients take fewer than five drugs is approximately 5%. When patients are

given 20 or more drugs, the incidence of adverse reaction rises to 45%. The average hospitalized patient receives 14 drugs during his hospital stay. One of the most bizarre manifestations is the hypertensive sympathomimetic crisis in individuals who have eaten cheese while on monoamine oxidase inhibitors. One of the most common drug inter-actions among older people is that between digitalis and thiazides, or other drugs likely to cause potassium depletion. In the presence of hypokalemia, digitalis may produce cardiac arrhythmias which greatly impede the control of digitalization. Parallel problems have also been observed in patients with gout with salicylate inhibition of the uricosuric effects of probenecid sulfinpyrazone.

Large amounts of licorice may also bring about potassium depletion especially if the patient is taking a thiazide. ◀

"Mr. Active Member" profile Proves value of belonging

As veteran members realize, participating in association work and programs is a road to individual growth. Every responsibility accepted and discharged increases a man's stature and his ability to handle bigger and bigger assignments. This accords with the formula, "Belonging + Participation = Success."

Of course, it involves more than just "going through the chairs." As a member climbs the ladder of organization affairs, he broadens his horizon, practices teamwork, masters communication and creates a circle of life-long friends.

Do you question this? Then look around you at your next convention. Study the members you most respect, and you will note some characteristics they have in common. Put those together, and you have a "profile" or conglomerate image of Mr. Active Member. He is:

- Friendly and easy to be with, any time of day or evening, from breakfast through the banquet.
- Composed, relaxed, never bothered over trifles.
- As interested in what you say as he is in what he has to tell you.
- Generous with praise for others' accomplishments, silent or understanding about their failures or faults.
- Stimulating in his grasp of association and industry problems and potentials.
- Innovative: receptive to new ideas, suggestions and approaches.
- Always ready to help.

The happiest thing about this profile is that it fits so many members—both reason and proof of your success as an association.

GOOD SAMARITAN LAWS

	Year of enactment of Good Samaritan Law	Covers any emergency or accident	Covers roadside accidents only	Covers only physicians licensed in the state	Covers out-of-state physicians	Covers physicians and other health personnel	Covers everyone	Does not cover acts of negligence or misconduct	Covers gratuitous services only
Alabama	1966	●			●	●		●	●
Alaska	1967	●					●	●	●
Arizona	1967	●				●	●	●	●
Arkansas	1963	●					●	●	●
California	1959	●		●		●		●	
Colorado	1965	●			●	●		●	
Connecticut	1963	●			●	●		●	●
Delaware	1963	●				●		●	
Dist. of Columbia	1966		●			●			●
Florida	1965	●					●	●	●
Georgia	1962	●					●	●	●
Hawaii									
Idaho	1965	●				●	●	●	
Illinois	1965	●			●	●		●	
Indiana	1963	●				●		●	
Iowa									
Kansas	1965	●			●	●		●	●
Kentucky									
Louisiana	1964	●			●	●		●	●
Maine	1961	●				●		●	
Maryland	1963	●		●				●	●
Massachusetts	1962		●		●			●	
Michigan	1963	●			●	●		●	
Minnesota									
Mississippi	1962	●				●		●	
Missouri									
Montana	1963	●					●	●	●
Nebraska	1961	●				●		●	●
Nevada	1963	●				●	●	●	●
New Hampshire	1963		●		●			●	●
New Jersey	1963	●				●	●	●	
New Mexico	1963	●					●	●	●
New York	1964	●			●			●	●
North Carolina	1965		●				●	●	
North Dakota	1961	●			●			●	
Ohio	1963	●					●	●	●
Oklahoma	1963	●				●	●	●	
Oregon	1967	●				●		●	●
Pennsylvania	1963	●				●		●	
Rhode Island	1963	●			●			●	●
South Carolina	1964	●				●		●	●
South Dakota	1961	●				●		●	
Tennessee	1963	●					●	●	●
Texas	1961	●					●	●	●
Utah	1961	●				●		●	
Vermont									
Virginia	1962		●					●	
Washington									
West Virginia	1967	●				●		●	●
Wisconsin	1963	●				●		●	
Wyoming	1961	●					●		●
TOTAL		39	5	2	12	26	16	43	25

Reprinted from *Resident and Staff Physician*, March, 1970.

Supreme Court decision in Hepatitis case

On September 29, 1970 the Illinois Supreme Court handed down a decision in the case of *Cunningham vs. MacNeal Memorial Hospital*, holding that the hospital was liable in damages to a patient alleged to have contracted hepatitis from a blood transfusion.

Mrs. Cunningham received a blood transfusion while in the hospital and later came down with hepatitis, which the suit alleges was caused by the blood used in the transfusion. The hospital defended upon the grounds that a blood transfusion is a service rather than a product and therefore, the strict liability or product warranty theory should not apply.

The Supreme Court held the fact that there is no definite scientific test for hepatitis makes no difference, as there is an implied warranty that the blood so used is free from any impurities.

While the hospital was the only one sued in this case the decision would indicate that the physician involved, as well as the blood donor, and all persons, firms or corporations in any way handling or processing the blood would also be liable, if sued.

The ramifications of the decision are many and the result is a great setback for medicine. All persons involved in the handling of blood, including the physicians and hospitals, are subject to suit, insurance premiums will necessarily increase, some physicians may refuse to perform transfusions, many blood donors will be afraid to give blood, and some blood banks may eliminate this service.

Anticipating the possibility of such a decision,

House Bill 616 was introduced at the 1969 session of the legislature, which would have declared blood, corneas, bones and other organs or human tissues, when transfused or transplanted, to be a service rather than a product. The bill unfortunately, did not pass. This bill specifically provided that no warranty of any kind attached to such items and that persons handling them would not be liable for any impurities contained therein. The Illinois State Medical Society and the Illinois Hospital Association will cause to be reintroduced, in the 1971 session of the legislature, a bill similar to House Bill 616, and will attempt to obtain all possible support for its passage.

While no one can say with absolute certainty that a written consent form, in which the patient requests the blood and consents to the procedure, will constitute a defense, such a consent should be used in all cases, for there is a good chance that the Courts would uphold. Following is a suggested joint consent which could be used by physicians and hospitals, which hopefully would cover everyone associated with the blood and its use. It is to be noted that the form is to be signed by the patient in the presence of a Notary Public. The notarization is not a specific legal requirement but it is felt that by so doing, more authority is added to the form, that the patient or his heirs would have difficulty in stating that the consent was not voluntary and therefore its chances of being accepted by the Court should be enhanced. If the attestation of the Notary Public is not used, it should be deleted from the form.

REQUEST FOR TRANSFUSION OF WHOLE BLOOD OR ANY OF ITS COMPONENTS

I, _____, do hereby request Dr. _____ and any of his assist-
(Attending Physician)

ants or associates (hereinafter called physician) to administer to me such blood transfusions or any blood components including, but not limited to, plasma, as may be deemed advisable in the judgment of any such physician.

It has been explained to me that it is not always possible to detect the existence or non-existence of some elements occasionally present in blood such as the virus causing infectious hepatitis or other unusual blood components and that there is a possibility of ill effects, such as Infectious Hepatitis resulting from the transmission of its virus or a transfusion reaction resulting from the transmission of unusual blood components. I also understand that there is the possibility of the transmission of the causative agent of other diseases.

It has also been explained to me that emergencies may arise when it is not possible to make adequate cross-matching or other tests and that immediate need may make it necessary to use existing stocks of blood which may include some incompatible blood types or substances.

It is understood and expressly agreed that the blood supplied in accordance with this agreement is incidental to the rendition of services and that no requirements, guarantee or warranty of fitness, quality or absence of undetectable substances such as viruses shall apply.

After considering all of the items set forth above and the possibility of adverse results from the said blood transfusions, it is still my desire that one or more transfusions of blood or its components be administered to me, if in the opinion of my physician such transfusions are needed.

I hereby assume any and all risks in connection with any said blood transfusions and release physician and _____ Hospital of _____, Illinois, its personnel and employees, all blood donors and all other persons, firms and corporations which in any way handled or processed said blood, from any responsibility whatsoever for any resulting contraction of viral hepatitis or any reaction from any such transfusion.

I further assume any and all risks in connection with said blood transfusions and agree that I will never bring suit in connection with said transfusions.

IN WITNESS WHEREOF I have hereunto set my hand and seal at _____ M. on this the _____ day of _____, A.D. 19_____

STATE OF ILLINOIS)
) SS
COUNTY OF _____)

_____ (SEAL)

I, _____, a Notary Public in and for said County in the State aforesaid, do hereby certify that _____ personally known to me to be the same person whose name is subscribed to the foregoing instrument, appeared before me this day in person, and acknowledged that _____ he signed, sealed and delivered the said instrument as his free and voluntary act for the uses and purposes therein set forth.

GIVEN under my hand and notarial seal this _____ day of _____, A.D. 19_____

Notary Public

University of California offers Master of Public Health degree

The Division of Maternal and Child Health of the University of California School of Public Health at Berkeley announces postgraduate programs leading to the degree of Master of Public Health. These programs are for pediatricians, obstetricians, and other physicians interested in receiving training in the field of Maternal and Child Health. Fellowship support is available, including basic support for the trainee, an allowance for dependents, tuition and fees.

Program areas now available include nine-month programs in Maternal and

Child Health, Health of School-Age Children, and Maternal Health and Family Planning. A twenty-one month program in Care of Handicapped Children, Perinatology, and Comprehensive Care is available. There are also three-year Career Development Programs in Pediatrics and Obstetrics which combine Public Health and Residency training. Fellowships are available for these programs also.

Applications are now being accepted for the group entering September, 1971. For information, write to Helen M. Wallace, M.D., School of Public Health, University of California, Berkeley, California 94720.

**NEW
PHARMACEUTICAL
SPECIALTIES**

by Paul deHaen

For detailed information regarding indications, dosage, contraindications, and adverse reactions, refer to the manufacturer's package insert or brochure.

Single Chemicals: Drugs not previously known, including new salts.

Duplicate Single Products: Drugs marketed by more than one manufacturer.

Combination Products: Drugs consisting of two or more active ingredients.

New Dosage Forms: Of a previously introduced product.

The following new drugs have been marketed:

NEW SINGLE CHEMICAL

PERGONAL Fertility Agent R
Manufacturer: Cutter

Nonproprietary Name: Menotropins

Indication: Induction of ovulation and pregnancy in the anovulatory infertile patient in whom the cause of anovulation is secondary and not due to primary ovarian failure.

Contraindications: A high level of urinary gonadotropin. Overt thyroid and adrenal dysfunction. Organic intracranial lesion. Any cause of infertility other than anovulation as stated in indications. Abnormal bleeding of undetermined origin. Ovarian cysts or enlargement not due to polycystic ovary syndrome. Pregnancy.

Dosage: Must be individualized. Initial dose should be 75 I.U. of FSH and 75 I.U. of LH (one ampule) per day, i.m. for 9 to 12 days followed by 10,000 I.U. of human chorionic gonadotropin (HCG) one day after last dose of PERGONAL.

Supplied: Ampuls

DUPLICATE SINGLE PRODUCTS

FLUOROPLEX,
Topical Solution Cancer Chemotherapy R

Manufacturer: Herbert, Div. Allergan

Nonproprietary Name: Fluorouracil

Indications: Multiple actinic (solar) keratoses

Contraindications: Hypersensitivity to component
Dosage: Apply twice daily with sufficient solution to cover lesion. Continue medication until inflammatory reaction reaches the erosion, necrosis and ulceration stage.

Supplied: Solution, 1% in 30 cc dropper bottle

HIPPUTOPE Diagnostic-Organ Function R
Manufacturer: Squibb

Nonproprietary Name: Sodium Iodohippurate I 131

Indications: Appraisal of individual kidney function

Contraindications: Should not be administered to women who are or may become pregnant, or during lactation unless need for agent outweighs potential risk from radiation.

Dosage: General range: i.v. 5-25 μ Ci, do not exceed.

Supplied: Multidose vials, 0.5-5.0 μ Ci

COMBINATION PRODUCTS

BIAVAX Biological R

Manufacturer: Merck Sharp & Dohme

Composition: Live rubella virus vaccine, HPV-77 strain Mumps vaccine, Jeryl Lynn virus strain

Indications: Simultaneous immunization against rubella and mumps

Contraindications: Pregnancy or possibility of pregnancy within three months after vaccination. Routine immunization of adolescent and adult women. Persons in whom either of the component vaccines is contraindicated. Sensitivity to chicken, duck, chicken or duck eggs or feathers or neomycin. Febrile respiratory illness or active febrile infections, blood dyscrasias, leukemia, lymphomas or malignant neoplasms affecting bone marrow or lymphatic system. Gamma globulin deficiency, or concomitant therapy with ACTH, corticosteroids, irradiation, alkylating agents or antimetabolites.

Dosage: Single injection

Supplied: Vials, single dose

DUOHALER Bronchodilator R

Manufacturer: Riker Laboratories

Composition: Each measured dose contains:

Isoproterenol HCl 0.16 mg.

(Equivalent to 0.137 mg. isoproterenol base)

Phenylephrine bitartrate 0.24 mg.

(Equivalent to 0.126 mg. phenylephrine base)

Indications: Relief of dyspnea resulting from bronchospasm, congestion and edema of the tracheobronchial tree.

Contraindications: Hypersensitivity to either agent. Pre-existing cardiac arrhythmias associated with tachycardia.

Dosage: 1 to 2 inhalations 4 to 6 times daily.

Supplied: Aerosol instrument

RENOTEC Diagnostic-Organ Function R

Manufacturer: Squibb

Composition: Technetium^{99m} complexed with Chelating agent DTPA (Diethylene Triamine Pentacetic Acid)

Indications: Kidney Scanning

Contraindications: None mentioned

Dosage: i.v., one unit dose

Supplied: Kit of five unit doses

NEW DOSAGE FORM

TESLAC Cancer Chemotherapy R

Manufacturer: Squibb

Nonproprietary Name: Testolactone

Indications: Palliative treatment of advanced or disseminated breast cancer in post menopausal women.

Contraindications: Breast cancer in men

Dosage: One tablet t.i.d.

Supplied: Tablets, 50 mg.

You Need to Keep Moving

"Business is like riding a bicycle—either you keep moving or you fall down." Anonymous

Mead Johnson Labs to sponsor Program on cancer chemotherapy

Mead Johnson Laboratories will sponsor a Cancer Chemotherapy Program in 1971. The program will consist of lectures to be given by outstanding medical authorities in the field of cancer chemotherapy. Fourteen M.D.'s, all with hospital, university or clinic affiliations will deliver the lectures.

Medical organizations interested in obtaining one of the speakers should contact:

Martin E. Vancil, M.D.
Associate Director
Medical Research Department
Mead Johnson & Company
Evansville, Indiana 47721.

Mead Johnson Laboratories will make arrangements for speaker procurement and will defray expenses for honoraria, travel and lodging.

Efudex by Roche available for solar keratoses treatment

A new approach to the treatment of solar keratoses is now available in the form of a topical agent, *Efudex* (fluorouracil), which has just been introduced by Roche Laboratories, division of Hoffmann-La Roche Inc.

Efudex (fluorouracil) is useful for the topical treatment of multiple actinic or solar keratoses. This has been demonstrated in clinical studies covering 727 patients. The active ingredient of *Efudex* is 5-fluorouracil, a fluorinated pyrimidine which is an antineoplastic antimetabolite. While fluorouracil affects cell growth and division of all cells, its effect is most marked on those cells which grow more rapidly and which therefore take up the drug at a more rapid pace.

Efudex is available in both topical solution and as a cream; *Efudex* solution contains either 2% or 5% of fluorouracil on a weight/weight basis, compounded with propylene glycol, tris (hydroxymethyl) amino-methane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Efudex cream contains 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60, and parabens (methyl and propyl).

For contraindications, warnings, precautions, and adverse reactions, dosage and administration, the attached package insert should be consulted.

Attendance: Prescription for Improving perspective

There weren't many conventions in the Fifteenth Century, but Leonardo Da Vinci said something that applies directly to those we hold today. The immortal who gave us *Mona Lisa* and *The Last Supper* counseled a contemporary:

"Every now and then, go away and have a little relaxation. When you come back to your work, your judgment will be surer. But to remain constantly at work will cause you to lose power of judgment.

"Go some distance away, because then the work appears smaller. More of it can be taken in at a glance, and lack of harmony or proportion more readily seen."

Two years ago, Dr. Philip Thomsen, then president of ISMS, made national headlines by accusing his alma mater, the University of Illinois, of de-emphasizing the family practice of medicine and of not producing enough physicians of any kind. His pungent comments resulted in his own school—and most others as well—taking steps to increase their enrollments and revising their medical curriculae to educate more family practitioners.

For many years ISMS has been aware that fewer and fewer physicians have been going into general practice. Pleas for a physician have been heard from the smaller towns throughout the state, and many devices have been employed to encourage one to settle in a rural area. These measures included guarantees of money while going

ISMS thought it advisable to try to find out what the 5,000 students, interns and residents who now are in training in Illinois plan to do. Early last spring, questionnaires were sent to 5,000 students; 1,396 or 28 per cent were returned.

The first question asked was "Is your home in Illinois?"

591 Students		
Yes	No	No answer
392 (66%)	184 (31%)	18 (3%)
252 Interns		
156 (61.5%)	88 (35%)	8 (3%)
550 Residents		
398 (72.3%)	133 (24%)	19 (3%)

The plans of our doctors In training

First Article

BY J. ERNEST BREED/CHICAGO, ISMS president

to school—providing the young doctor would come back to practice—provision of a very fine office free of charge, guarantees of income, etc.

Only about 30% of those we educate stay in the state, and of these only about one-third go outside Cook County to practice. Last year still greater efforts were made to encourage young doctors to stay in Illinois and to practice outside Cook County. Still, the demands for doctors continue to increase, while demands for controls over the distribution of physicians from people outside the profession become louder.

Realizing that another 5 to 10 years will pass before the increase in medical students will materially increase the number of physicians looking for a place to practice,

It is surprising that so large a percentage (66%) of our students come from Illinois, since only one of the five medical schools is a state school to which state residents pay a lower tuition. It is reasonable that a higher percentage (72.3%) of residents come from this state since many plan to practice in their home state and it is usual for a young doctor to take his residency in the state in which he plans to practice.

"Do you plan to: (A) practice medicine, (B) do medical research (C) confine your efforts to teaching?"

591 Students			
	Yes	No	Undecided
(A)	572 (95%)	4 (1%)	34 (5%)
(B)	105 (18%)	183	306
(C)	55 (9.25%)	220	319

Since these figures add up to over 100%, it is obvious that at the student level, indecision is prevalent. However, it does indicate that many plan to do other than attend sick people.

The corresponding questions and answers received from 252 residents, were 193 (76%) yes, 6 (2.3%) answered no, and another 53 did not answer the question.

Five hundred and fifty residents answered the question as follows: practice medicine 480 (87.2%), do medical research, 130 (23.5%), confine efforts to teaching 134 (24.3%).

These replies are difficult to assess. They do disclose that the further students go along in their training, a greater percent plan to go into teaching or research and fewer plan to practice medicine; 93.5% of students plan to practice, 87.2% of residents; 9.25% of students plan to confine their efforts to teaching while 24.3% of residents state this as their plan.

When one realizes that many physicians practice for a time, then take administrative jobs in industry, hospitals or other organizations, it becomes obvious these physicians along with those who plan to do research and teach, will be lost to society as "practicing physicians."

The next question concerns the place of practice and was answered as follows:

	<u>594 Students</u>		
	Yes	No	No answer
Do you plan to practice in Illinois?	153 (25.76%)	351 (59%)	90 (15.1%)
Do you plan to practice in Chicago?	89 (58.1%)		
Do you plan to practice elsewhere?	66 (43%)		
	<u>252 Interns</u>		
Do you plan to practice in Illinois?	77 (30.5%)	77 (30.5%)	98 (38.8%)
Do you plan to practice in Chicago?	57 (74%)		
Do you plan to practice elsewhere?	20 (26%)		
	<u>550 Residents</u>		
Do you plan to practice in Illinois?	222 (40.3%)	182	
Do you plan to practice in Chicago?	143 (26%)	104	
Do you plan to practice elsewhere?	80 (36.5%)		

It is disheartening to find that only 25.75% of students, 30.5% of interns and 40.3% of residents plan to practice in Illinois. Since the student frequently takes his internship and residency in the state in which he plans to practice, it is reasonable to see the increased percentages in these groups. It is still more distressing to learn that only 43% of students, 26% of interns and 36.5% of the residents who plan to stay in Illinois are going to practice medicine outside of Cook County.

Saying it another way, of 594 students, only 66 or 11% have decided to practice in Illinois, outside of Cook County; 8% of 252 interns and 14% of 550 residents have made the same decision.

The medical profession is responsible for the health care of the people. ISMS must assume leadership in providing care for all the people who live in Illinois. There are two areas in which medical care is badly needed—the ghettos of the cities and the rural areas. Because of the many non-medical difficulties encountered in providing ghetto residents with medical care, many groups beside the medical society are helping. Unfortunately, there is little coordination between the different groups, which include the federal government, the city government, and the different medical schools, different hospitals and community groups. ISMS and the Chicago Medical Society assist all of these groups working in the city ghettos as much as possible.

Since outside of Cook County there is little effort by other organizations to supply medical care to areas of great medical need, ISMS, with little success, has attempted to encourage young doctors to practice outside Cook County. It appears from our survey results that the young doctors now in training in Illinois will follow the same pattern as their recent predecessors. For this reason, we are fostering new systems of medical practice that are designed to attract the young specialists into towns and smaller cities of the state.

The second article based on the questionnaire sent to the students, interns and residents will be published next month, disclosing the type of practice the young doctors are planning to embrace. With this information, we are in a better position to attract young doctors to areas outside the large cities. ◀

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 Warren W. Young, M.D., Chicago

Crash program needed for family doctors

"To Avert Family Doctor Shortage, HEW To Take Over All Medical Schools." Such a headline could appear tomorrow, but with foresight, we may never need a crash program to abort such a takeover. U.S. medicine's usual "too little, too late" may find us in just such a spot. There are groups that would like to take over American medicine; recently, Senator Edward M. Kennedy (D. Mass.) announced his plan.

But what sort of crash program could produce the needed family doctor? A seemingly simple solution would be to require every graduate of the next senior class to go into general practice for two years, thus the shortage could be solved in a matter of months. This could produce a shortage of specialists two years hence, but I doubt it, for by then, the medical schools could have had time to increase their enrollment. Also, the political pressure would be off soon after the family doctor shortage was relieved and we could solve the shortage in our own way.

Would the two years of general practice before taking up a specialty be a bad thing? G.P.s say, "no," they've often wished for specialists that saw not just an eye, or hernia, but a whole person. Every specialist could not help but benefit by a general practice background. After spending time

in general practice, the specialty training time could be cut—all of us who teach have immediately given older residents (coming back from general practice) more responsibility sooner. Learning to assess many patients from a general point of view cannot help but make a better surgeon, internist, psychiatrist, dermatologist, pediatrician. Thus, the specialties would gain from such a crash program and probably residency times could be cut because of the better motivation and G.P. background of these older, more experienced men.

It seems to me, that once started, many men would stay on in general practice, for they would realize what a rewarding life it can be, a fact seldom pointed out to medical students taught solely by full-time specialists. Those men committed to a special program, knowing that it would be only two years, could be encouraged to practice in ghettos or depressed areas where physicians are loathe to settle for life; another political talking point negated.

Many medical students are married. A wife who has done without, to see her husband through school, and who has lived in the substandard housing that surrounds most medical schools will enjoy being the wife of "the doctor," and the approbation that goes with it in any community. For

once, she'll be more than one of the many unknown wives of those lowest in the hierarchy.

But this suggestion for a crash program is just that—"if" the pressure is suddenly put to bear to produce more family doctors. Senator Kennedy, with his phenomenal press coverage is making the "if" rather

possible. If we must provide family doctors in a hurry, we do have a means to put (current figures) graduates in family practice within one academic year. It might just avert a takeover. Faults our system might have, yet all critics—domestic and foreign—agree that American medicine is still the best in the world. Let's keep it that way.

Hugh A. Johnson, M.D.

The controversy over Vitamin E

Over-the-counter sales of vitamin E have more than doubled in the past few years. There is no scientific basis for the popularity of vitamin E. It stems from word-of-mouth recommendations among laymen and certain physicians. There is no doubt that the product is controversial. Its therapeutic value is unsettled despite the many reports in the world medical literature. Most of these are animal studies.

Vitamin E is the name of a group of closely related tocopherols. These compounds act as antioxidants in naturally-occurring fats by inhibiting the oxidation of unsaturated fatty acids and vitamins A and C. Alpha-tocopherol is the most plentiful type of vitamin E, and is available in oral and parenteral forms, mainly as D-alpha-tocopherol acetate.

Vitamin E is widely distributed in animal and vegetable foods and is found in most vegetable oils and leafy vegetables. Wheat germ oil is especially rich in E. For these reasons, a deficiency of the vitamin is rarely encountered. Infants may require supplementary vitamin E when dietary fat is markedly reduced as well as children with prolonged steatorrhea. Reports show that premature infants with hemolytic anemia respond to vitamin E.

Opinions vary widely as to the value of alpha-tocopherol in the prophylaxis and treatment of various diseases. The proponents of the controversial vitamin claim that it prevents clotting of blood via fibrinolysis. As an antioxidant, tissues (including the heart and brain) need less blood. In addition, vitamin E is a capillary and artery

dilator. And finally, vitamin E prevents excess scar tissue. Consequently, it is useful in Dupuytren's contracture and Peyronie's disease.

The proponents of E have used these four functions of the vitamin as rationale in the treatment or prophylaxis of coronary heart disease, hypertension, venous thrombosis, intermittent claudication, muscular dystrophy, amyotrophic lateral sclerosis, threatened or habitual abortion, infertility, diabetes, nephritis, and many other conditions.

However, despite reports and claims to the contrary, most physicians are not convinced that alpha-tocopherol will do this. Here is where we stand today. J. F. Stare was quoted as saying, "... To the best of our knowledge, ill health in humans in the United States of America has never been associated with a lack of vitamin E nor has it been improved by giving extra amounts of vitamin E. . . ."

Dr. Evan V. Shute, the chief proponent of vitamin E states, "... Now any heart patient can treat his own condition better than the best cardiovascular specialist in the country by going to a health food store and asking for vitamin E across the counter. Isn't it time that the cardiologists swallowed their pride and tried to find out what so many laymen already know? . . ."

We wish it were this simple to treat serious diseases. Unfortunately too much reliance is placed on subjective evidence and too little on objective findings, especially when the product in question is safe to take in almost any dosage.

T. R. Van Dellen, M.D.

Inflation takes a big bite

Inflation continues to rob workers of increased earnings. A worker who 10 years ago was making \$6,000 a year, and who today is earning \$9,000, is actually only \$340 better off.



What every doctor should know...

BY JESSIE BREINIG/CHICAGO

Medical Assistants in Illinois, employed by a practicing M.D., should become members of the Illinois Medical Assistants Association.

The objects of this organization are:

1. To elevate the standards among those employed as Medical Assistants.
2. To encourage its members at all times to practice medical ethics, honesty and loyalty, and to render more efficient service to the medical profession.
3. To promote an educational program designed to enlist those interested in a career as a medical assistant.

Illinois Medical Assistants Association has the approval of the Illinois State Medical Society and is affiliated with the American

Association of Medical Assistants, approved by the American Medical Association.

This Association is declared to be non-profit, it is not nor shall it ever become a trade union or collective bargaining agency. Doctor, encourage your Medical Assistant to join Illinois Medical Assistants Association. Not only will she profit from it because of its educational and teaching programs, but she will also enjoy the association of other women throughout the state, who are dedicated to the work of the Medical Assistant.

Further information regarding membership in this organization can be obtained through Mrs. Norma Domanic, 150 Ash Street, New Lenox, Ill. 60451 or Mrs. Vivian Kraft, R.R.#2, Normal, Ill. 61761.

The dying patient speaks out

It has been said that 80% of dying patients know that they are dying and would wish to talk about it and that 80% of doctors deny this and believe that the patient should not be told. My experience with patients in chronic renal failure showed that all these patients had considered their own death and that most were able to discuss their feelings and beliefs with awareness and relief. Only a small number used the defense of denial and stated that they had not envisaged the matter as applying to themselves. From their manner of conversation characterized by shifts of direction and silences it was clear, however, that death as a personal possibility was present in their thoughts, though they were not prepared to discuss it openly at that particular time.

This, then, would appear to be the first major point—namely, that seriously ill patients do consider death as a possible outcome and welcome the chance to talk about their feelings. The fact of sharing this fear with the doctor is in itself therapeutic and promotes more comfortable communication between patient and doctor. It must be emphasized, however, that discussion of this fear, whether or not it is founded in reality, should be carried out only when the relationship between patient and doctor is sufficiently close; both should have reached the stage of feeling at ease with each other. (W. A. Cramond.: *Psychotherapy of the Dying Patient*, **British Medical Journal** (Aug. 15) 1970, pages 389-393.)

Looking for a Place to Practice? Placement Service Lists Openings

In an effort to reduce the number of towns in Illinois needing practicing physicians, the *Journal* is publishing synopses submitted to the Physicians Placement Service concerning openings for doctors.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the placement service.

Information and comments are also requested from physicians living near the communities listed as to the real need and the ability of the town to support additional physicians.

Inquiries and comments should be directed to Mrs. Robert Swanson, Secretary, Physicians Placement Service, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601.

Subsequent to the listings over the past 30 months, the following supplemental list of openings is furnished. This will be continued next month.

BUREAU COUNTY: Princeton; population: 6500. Trade area: 10,000. Opening with two physicians or solo. Eight doctors here including four G.Ps. Hospital three blocks from office, 130 beds. Small industry and agriculture. Protestant and Catholic churches. Public and parochial schools. Country club with golf course. Sixty miles from Peoria. New office ready and waiting. Weekend, holiday and vacation relief call. For further information contact: G. E. Rathburn, M.D., 730 South Main, Princeton.

COOK COUNTY: Chicago. Opening for associate medical director of large manufacturing company. Prefer general practitioner, internist or surgeon. For further information contact: Mr. Carl Von Ammon, Boyden Associates, 111 W. Monroe, Chicago. Phone: 312-782-1581.

COOK COUNTY: Chicago. Forty-five man group established in 1941; largest private medical clinic in Cook County. Opening for GP or internist. All specialties represented in group. Salary: \$24,000 for GP; \$26,000

for internist. Opportunity for partnership after two years. Nearby Ravenswood Hospital expanding to 500 beds in 1971. One block from clinic. For further information contact: Kenneth Hatfield, M.D., Field Clinic, 4600 N. Ravenswood, Chicago. Phone: 312-561-2525.

COOK COUNTY: Chicago. Opening for an associate—GP or internist. Open immediately. Financial arrangement negotiable. Doctor owns building with pharmacy, dentist and optometrist as tenants. Near Mt. Sinai and Evangelical Hospitals. For further information contact: Marvin Lerner, M.D., 4900 South Archer Ave., Chicago. Phone: 312-581-7056.

DUPAGE COUNTY: Warrenville; population: 5000. Opening for GP or internist. Percentage or salary. Three nearby hospitals. Thirty miles west of Chicago. For further information contact: Robert Allison, M.D., Warrenville. Phone: 312-393-1221 or 365-6364.

EFFINGHAM COUNTY: Effingham; population: 11,000. Trade area: 60,000. Nine physicians. St. Anthony Hospital; 64 beds. Seventy miles from Champaign & Terre Haute; 100 miles from St. Louis. Four drug stores. Agriculture and industry. Fifteen Protestant and Catholic churches. Six grade schools; two high schools. Three golf courses, two indoor pools. Lake, etc. Office space available. For further information contact: Mr. David Lustig, 111 W. Jefferson, Effingham. Phone: 217-342-2877.

FRANKLIN COUNTY: Christopher; population: 3,000. Trade area: 9000. Opening at Miners Hospital; 34 beds. Hospital will provide office, examining rooms, etc. Complete outside practice permitted. Six active physicians on staff. Nine nurses; three technicians. Travel expenses to job will be provided. Outpatient clinic with surgeon available two days a week for clinic. New grade and high school. Catholic and Protestant churches. Three miles from largest man-made lake in Illinois to be completed in 1971. Two new junior colleges within 20 minute drive. One hundred miles south of St. Louis. For further information contact: Mr. Eugene Helfrich, Miners Hospital, Effingham.

Editor's Note

Following is a synopsis of a report to the Illinois Department of Public Health, Division of Health Care Facilities & Chronic Illness, on the Pilot Project on Medical Review of IDPA patients in Long Term Care Facilities. The report was prepared by John W. Bowden, M.D., chairman, Long Term Institutional Care Committee, Will-Grundy County Medical Society.

In Will and Grundy Counties

Pilot project in medical

A nine-month pilot project on medical review of public aid patients in extended care facilities by physicians in Will and Grundy counties was successfully concluded June 30. The unique project was started at the request of the Illinois Department of Public Health to provide local physician participation in the medical review program. The project was so successful that the Will-Grundy Medical Society has authorized it be continued as an ongoing program.

Medical review of ECF's is required by federal law which provides for: (a) a regular review program including each patient's need for skilled nursing home or intermediate care; (b) periodic inspections to be made in all skilled nursing homes and intermediate care facilities within the state by one or more medical review teams composed of physicians and other appropriate health and social service personnel; and (c) complete reporting by the teams of their findings and recommendations.

Will-Grundy County Medical Society designated its Long Term Institutional Care Committee to implement the pilot program. This committee combined its activities with the Utilization Review Committee that already was performing medical

review of several ECFs in the community. The Medical Society felt its participation in this program would further demonstrate its concern for maintaining and upgrading the level of care in ECFs for all patients. The Society also felt local physicians could better evaluate the quality of care in the area's ECFs than could outside consultants.

The cases for review were selected by the Department's Division of Health Care Facilities and Chronic Illness. Cases were submitted to the review committee on a report form containing the evaluation of the physician and a registered nurse. These reports were assigned to an appropriate physician member of the review committee who visited the facility, studied the patient's medical record, and discussed the patient with the administrative and nursing staff. When indicated, he personally examined the patient.

There are nine nursing homes and four homes for the aged with a total bed capacity of 1,211 in the two county area. All homes but one (because it was recently constructed) were visited by the review committee. After review, cases were returned to the Medical Society office with the physician's bill for performing the review. A copy of the review was made for Society records and the case was then returned to the Di-

vision of Health Care.

As soon as the Medical Society received the Department of Public Health's payment, it issued a check to the physician. During the project no money was allowed for the administrative services of the Society's office. However, it has since been agreed that such administrative costs will be billed for in the future.

Project results

Positive results of the pilot project are:

1. Increased physician cooperation and par-

The 1970 ISMS House of Delegates passed a resolution (70M-24) endorsing county medical society participation in this medical review process.

2. Efforts should be made to standardize all essential forms used by physicians in treating ECF patients and by those physicians performing the medical review.
3. The Departments of Public Health and Public Aid should accelerate efforts to computerize all information relating to IDPA patients. This implies that ECFs would provide the necessary information

review successfully completed

ticipation, especially an improvement in visits to the facilities.

2. Better knowledge on the part of physicians of the level of care being delivered in ECFs.
3. An improvement in the quality of medical records.
4. Apparent improvement in patient transfer between ECFs, especially the transfer of records.
5. Improved coordination of efforts between physicians, facility nursing services and administrative personnel.
6. The start of an association of nursing homes that will provide a forum to discuss common problems ranging from management to the delivery of services.

Recommendations

Will-Grundy County Medical Society made the following recommendations to the Illinois Department of Public Health:

1. That all county medical societies be given the opportunity to accept or reject a plan to provide medical review in ECFs. Any agreement can be terminated by either party. If a county society decides it does not want to cooperate in such a program, the State of Illinois may employ a local physician (s) on a regional or area basis.

so that profiles could be obtained by: patient; disease category; utilization; physician visits; laboratory services; potential benefit from occupational or physical therapy; and over-all patient review by facility.

4. Savings in public aid funds achieved through more efficient reporting methods should be applied toward more adequate payment to ECFs through paying on a usual and customary charge basis. Such payment practice was recommended to IDPA in 1968, by the Ad Hoc Committee on Public Aid payment.

Conclusions

The Will-Grundy County Medical Society feels that county society participation in these programs is desirable and essential. Attempts should be made to implement similar programs on a statewide basis. As indicated, it is realized that all county societies cannot engage in these programs and in such cases the Department of Public Health has to employ a reviewing physician on a local or regional basis. Finally, it is essential to this program to computerize all information, to change the present payment mechanism, and for ECFs to voluntarily standardize forms used by physicians. ◀

Pacemaker for ailing brains in ten years?

Within the next ten years, pacemakers similar to cardiac pacemakers may be used in diagnosing and treating brain disorders, reports the National Society for Medical Research.

A joint project by a team of scientists at Yale Medical School and an Aeromedical Research Laboratory at Holloman Air Force Base in New Mexico has resulted in a chimpanzee named "Paddy" carrying on a two-way brain-radio communication with a computer. Electrodes implanted in the chimp's brain have enabled experiments to be conducted successfully for the past year and a half.

The experimental work "... introduces a new age in research and therapy on the brain and mind," according to Dr. Jose M. R. Delgado, professor of physiology at Yale and leader of the experimental group.

According to Dr. Delgado, it is also technically possible for one brain to communicate directly with another brain using the electronic and computer techniques shown to be feasible with this experiment. He indicated that there are several applications of this technique such as treating brain disorders in man and particularly diseases

known to be caused by electrical disturbances in the brain.

One application in the very near future, according to the Doctor, involves patients with epilepsy, intractable pain and Parkinson's disease, who may now be treated or diagnosed with the aid of cumbersome electronic instrumentation that restricts their hospital mobility. He noted that this new development may aid in the diagnosis or therapy of such brain disorders because of its convenience to both patients and physicians. A more far-reaching application, but one which may occur in the present decade, he said, will be brain pacemakers which, like cardiac pacemakers, will be miniaturized and implanted in the patient's body and will receive and send electrical information.

Using such a brain pacemaker, an epileptic in the future may have important areas of his brain's electrical activity monitored by remote computer. Electrical disturbances, which might have led to convulsive attacks, would be detected and corrected by the computer while the patient continued normal activities, uninterrupted by the now-blocked attack.

On specialization

"... for so many and of such narrow scope are the facets of medicine that the hackneyed description of a specialist as 'a man who knows more and more about less and less, till finally he knows everything about nothing,' seems almost justified.

This is due to what? I would say that it is undoubtedly due to the amazing advances in science and the discovery of how many there are which can be partially adapted to the needs of medicine. This naturally increased enormously the load of medical literature, so much so that in 1962, the editor of the *World Medical Journal* told us that each night, between sleeping and waking, more than 400 new articles appeared in medical journals, and there is no reason to believe that flood has lessened, or to even hope that it has. True, many of those articles were scarcely deserving of editorial acceptance, but as long as this curious belief exists, that appearance in print confers on the author the simulacrum of an authority, editors will continue to be deluged with copy, some good, much bad, and most indifferent.

A description of the ambitions of a budding young doctor in verse may prove to show how strongly this was held:

The pen, so springs the constant hope of all devout physicians,

Is mightier than the stethoscope and runs to more editions;

So while he waged bacillic wars, or sewed a clever suture,

His mind still hummed with metaphors, laid up against the future."

(Sir Alexander Murphy.: On Specialization. *Med. Jl. of Australia Supplement* (Saturday, Nov. 8) 1969, pgs. 49-51.)

Official Call For Scientific Exhibits

1971 ANNUAL MEETING OF ISMS
Arlington Park Towers — May 17-18-19

The Committee on Scientific Assembly invites members of the Illinois State Medical Society to submit applications for scientific exhibits at the Society's 1971 annual meeting May 17-19 at the Arlington Park Towers, Arlington Heights, Illinois.

To facilitate arrangements for the proper location of the scientific exhibits, individuals and organizations desiring space at the meeting are requested to file an application before March 15, 1971, giving the basic equipment which will be needed. Awards are given to exhibits of exceptional value. Assignments are made as exhibits approved by the Committee on Scientific Assembly.

There is no fee charged for scientific exhibits, but the exhibitor must pay the cost of installing the exhibit, of tables and chairs that may be rented, for alterations or all other construction. Single exhibit space is 8x10 feet.

Those interested in providing an exhibit are requested to file an application and a full description of the exhibit.

DEADLINE FOR APPLICATIONS: March 15, 1971.

Contact: Director of Scientific Exhibits
Illinois State Medical Society
360 North Michigan Avenue
Chicago, Illinois 60601

Director of Scientific Exhibits
Illinois State Medical Society
360 North Michigan Avenue
Chicago, Illinois 60601

Please send Scientific Exhibit Application Forms to:

NAME

ADDRESS

CITY & ZIP CODE

(Please Print)

Do you listen . . . and remember?

For about seven-tenths of his waking day, the average person is involved in some form of verbal communication. Nearly half that time, he is on the listening end. Unfortunately, according to Dr. Robert Haakenson, very little of what we hear is lastingly recorded.

Within 24 hours, the community relations expert says, we forget 50 per cent of what we heard. Another 25 per cent is erased in the next two weeks. In short, we lose three-fourths of what we hear.

The biggest reason for our forgetfulness is poor reception. Our listening speed is approximately four times as fast as words are spoken. So we habitually "think ahead" of the speaker and are inclined to stop listening while our subconscious waits for him to catch up. What he says in such lapses is bound to make little impression—but it could be most important.

When you feel your attention is flagging, remember the old warning, "Stop, Look and Listen!"

Health Insurance Claim Form available

Copies of the HIC form may be obtained by contacting Illinois State Medical Society, 360 N. Michigan Avenue, Chicago 60601.

HEALTH INSURANCE CLAIM — GROUP OR INDIVIDUAL				COMB-1 (10-67)
PART A TO BE COMPLETED BY PATIENT (INSURED) <i>Spaced for Typewriter — Marks for Tabulator Appear on this Line</i>				
PATIENT'S NAME AND ADDRESS			DATE OF BIRTH	
INSURED'S NAME IF PATIENT IS A DEPENDENT				
NAME OF INSURANCE COMPANY		POLICY NUMBER		INSURED'S SOCIAL SECURITY NUMBER
IF GROUP INSURANCE, NAME OF POLICYHOLDER (i.e., Employer, Union or Association through whom insured)				
AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the undersigned Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his services as described below but not to exceed the reasonable and customary charge for those services.			SIGNED (INSURED PERSON) _____ DATE _____	
AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned Physician to release any information acquired in the course of my examination or treatment.			SIGNED (PATIENT, OR PARENT IF MINOR) _____ DATE _____	
PART B ATTENDING PHYSICIAN'S STATEMENT				
1. DIAGNOSIS AND CONCURRENT CONDITIONS (IF DIAGNOSIS CODE OTHER THAN ICD-9 USED, GIVE NAME): _____				
2. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PREGNANCY? YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, APPROXIMATE DATE PREGNANCY COMMENCED: _____				
3. REPORT OF SERVICES (OR ATTACH ITEMIZED BILL) (IF PREVIOUS FORM SUBMITTED TO THIS CARRIER, YOU NEED SHOW ONLY DATES AND SERVICES SINCE LAST REPORT)				
DATE OF SERVICES	PLACE OF SERVICES	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	PROCEDURE CODE — IF USED (IF CODE OTHER THAN CPT-9 USED, GIVE NAME)	CHARGES
TOTAL CHARGES ▶ \$ _____			AMOUNT PAID ▶ \$ _____	
BALANCE DUE ▶ \$ _____			DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED.	
4. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED.			5. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION.	
6. PATIENT EVER HAD SAME OR SIMILAR CONDITION? YES <input type="checkbox"/> NO <input type="checkbox"/> IF "YES" WHEN AND DESCRIBE: _____			7. PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES <input type="checkbox"/> NO <input type="checkbox"/>	
8. PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK). FROM _____ THRU _____			9. PATIENT WAS PARTIALLY DISABLED. FROM _____ THRU _____	
10. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK.			11. PATIENT WAS HOUSE CONFINED. FROM _____ THRU _____	
12. DOES PATIENT HAVE OTHER HEALTH COVERAGE? YES <input type="checkbox"/> NO <input type="checkbox"/> IF "YES" PLEASE IDENTIFY _____				
13. I DO NOT ACCEPT ASSIGNMENT. <input type="checkbox"/>				
DATE	PHYSICIAN'S NAME (PRINT)	SIGNATURE	DEGREE	TELEPHONE
STREET ADDRESS		CITY OR TOWN		STATE OR PROVINCE
MEMORANDUM REGARDING DISPOSITION OF THIS FORM ON REVERSE SIDE			ZIP CODE	

SOCIO ECONOMIC *news*

A service of the Public Relations and Economics Division

BY JOSEPH J. LOTHARIUS

ISMS TRUSTEES RE-AFFIRMED THE USUAL AND CUSTOMARY FEE CONCEPT AS THE BASIS FOR

physician payment (initially adopted in 1966) rather than the relative value scale. The action was taken at the October board meeting after Trustees learned that the demand for ISMS Relative Value schedules was continuing. Board members agreed that the Relative Value studies should not be reprinted because the information contained in these booklets is as outdated as the relative value concept. All Illinois county medical societies will be informed of the Board's decision.

CAN YOU VISUALIZE A ROLE FOR BLUE SHIELD IN A PRE-PAID HEALTH PLAN?

No, says Dr. Cecil C. Cutting, executive director, Kaiser Permanente Medical Group, Oakland, Calif., a guest speaker at a recent national conference of Blue Shield executives. However, Dr. Cutting thinks that Blue Shield, with the cooperation of a medical society, could correlate a number of groups under one program. He said such cooperation could tie together such necessary functions as marketing and record keeping.

IF A NEW HEALTH CARE DELIVERY SYSTEM IS INTRODUCED, BLUE SHIELD SHOULD

BE A PART OF IT, according to William E. Ryan, senior vice-president, Marketing, National Association of Blue Shield Plans, speaking at the national Blue Shield conference. Ryan said thus far the "Blues" have not felt the competition from Foundations for Medical Care in those areas where the latter exist. "Their impact will grow as their enrollment grows," according to Ryan. He said the health market is ready for a change and is looking for something new. "We must convince the market that Blue Shield is the best way to go," Ryan said. He pointed out that in order to achieve this, Blue Shield must provide the public with the proper environment to make a decision."

WILL MEDICARE PAY PHYSICIANS FOR MONTHLY VISITS TO ECF PATIENTS IF THE VISIT

IS MADE ONLY TO CONFORM WITH ILLINOIS LAW? Yes, says the Bureau of Health Insurance, Social Security Administration. BHI said regulations covering visits to Medicare patients in extended care facilities are being eased so that one visit per month will be "automatically" allowed. "In the case of ECF patients receiving a non-covered level of care or patients in nursing homes that are not participating in ECFs, one visit a month by a physician can be presumed reasonable and necessary," according to BHI. "Such a visit, of course, could also serve to satisfy the 30-day visit requirement in the ECF conditions of participation and the state law."

GOVERNMENT MAY SOON BE SCRUTINIZING . . . AND REDUCING MEDICARE AND

MEDICAID PAYMENTS TO HOSPITALS. The HEW Secretary could reduce "unreasonable" payments to hospitals if the changes in the Medicare and Medicaid programs proposed by Rep. Wilbur Mills, chairman of the House Ways and Means Committee, are adopted. A report printed in a recent issue of *Private Practice* said the Mills' bill, designed to hold down hospital charges, would form regional boards which would determine what constitutes "reasonable" hospital charges.

Under the Mills bill, HEW would be ordered to publicize what costs, if any, were found to be unreasonably charged. The bill would also give states power to determine what hospital charges to Medicaid were reasonable.

MEDICARE INSURANCE DEDUCTIBLE AND CO-INSURANCE WILL INCREASE IN '71.

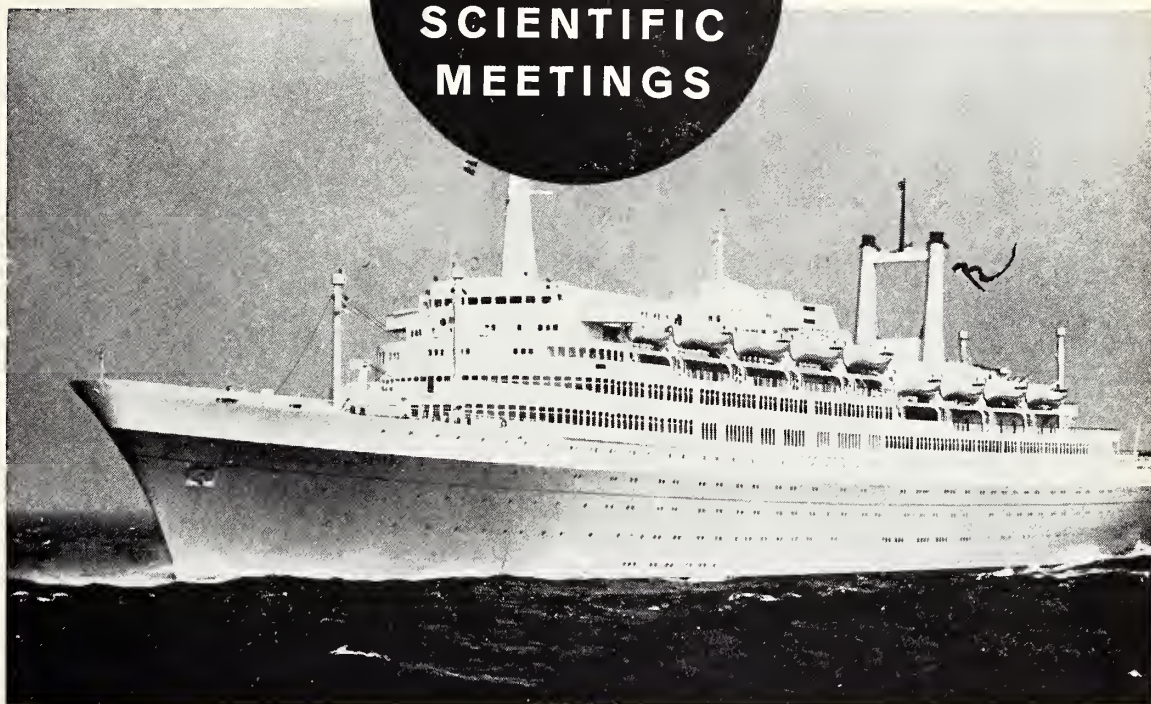
HEW has announced the inpatient hospital deductible under Part A of Medicare will be increased from \$52 to \$60 for benefit periods beginning in 1971. The HEW announcement also specifies that co-insurance amounts must be proportionate to the inpatient hospital deductible. The new amounts are effective only with benefit periods starting in 1971. The present \$52 inpatient hospital deductible and related co-insurance amounts remain in effect for benefit periods starting in 1970, even though these periods extend into 1971.

Ten ways to help your association

Keeping an association up to par is a year-round job for all the members. Officers and staff plug away at it continually, but the need for constant renewal calls for transfusions from everyone. To show how the rank and file can help, the Texas Automobile Dealers Association listed 22 suggestions. Here are ten selected:

1. Attend meetings regularly.
2. Show a personal interest.
3. Stir up listless members.
4. Promote a team-work spirit.
5. Be a peacemaker.
6. Seek the best interest of everyone.
7. Give credit where it is due.
8. Prevent meetings from bogging down.
9. Don't duck thankless jobs that must be done.
10. Keep long-range goals in mind.

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Meeting Memos

Nov. 17—Illinois State Psychiatric Institute

Lecture "Community Psychiatry—Current Prospects and Problems"
ISPI Auditorium, 1601 W. Taylor, Chicago

Nov. 20—Diabetes Association of Greater Chicago

Symposium
Holiday Inn, 644 N. Lake Shore Dr., Chicago

Nov. 20-21—Institute of Medicine of Chicago

Workshop on "The Doctor and His Changing Community"
Ambassador West Hotel, Chicago

Nov. 20-21—University of Iowa

Workshop on Sports Medicine
University of Iowa, Iowa City, Iowa

Nov. 27-29—National Commission on Human Life Reproduction and Rhythm

5th International Symposium On Abortion, Family Planning And Sex Education
Sheraton Plaza Hotel, Boston

Nov. 29-Dec. 2—Association of Military Surgeons of the U.S.

77th Annual Meeting
Washington Hilton Hotel, Washington, D.C.

Nov. 29-Dec. 2—American Medical Association

24th Clinical Convention
Statler Hilton Hotel, Boston

Nov. 29-Dec. 2—American Medical Association

12th National Conference on the Medical Aspects of Sports
Sheraton-Boston Hotel, Boston

Dec. 1—Illinois State Psychiatric Institute

Lecture "Russian and American Psychiatry—A Comparison"
ISPI Auditorium, 1601 W. Taylor, Chicago

Dec. 4—Chicago Surgical Society

Scientific Session
Chicago Surgical Society, Evanston

Dec. 5-10—American Academy of Dermatology

29th Annual Meeting
Palmer House, Chicago

Dec. 9—University of Chicago

Frontier in Medicine Lecture "Recent Concepts in the Management of Burns"
Billing Auditorium, Billings Hospital, Chicago

Dec. 18-19—University of Kentucky

Postgraduate course, "Practical Ophthalmology for the Primary Physician"
University of Kentucky Medical Center, Lexington, Kentucky

Christmas Seal Campaign: Help Fight TB and RD

"Use Christmas Seals. Help Fight TB and RD." is the theme of the 1970 Christmas Seal Campaign, running November 10 through December.

The goal set by The Tuberculosis Institute of Chicago and Cook County is to focus attention on the Tuberculosis problem and raise \$1,100,000 to support the fight against TB and RD.

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Doctors warned of crisis in mounting drug abuse

More than 1,400 doctors in the New York area were told that if America does not solve its mushrooming drug addiction problem within the next ten years our civilization may find it difficult to survive.

The grim warning was sounded by a distinguished panel of psychiatrists and physicians speaking at a symposium on drug abuse sponsored jointly by the New York Academy of Medicine and Pfizer Laboratories at the Americana Hotel recently.

The increase in addiction, these experts said, is geometric and already out of hand because there is no clear-cut or apparent solution. In New York City alone, it was reported, there were 900 deaths last year from drug overdose.

The panel made these essential points:

- Education, whether it be lectures to the public or classes for children, has little effect. Young drug users lack motivation to stop and motivation must be supplied before a cure can be effective.

- Physicians see a growing menace in the misuse of non-narcotic drugs intended for other uses such as amphetamines, tranquilizers and sleep hypnotics. Amphetamines may be prescribed by physicians for obesity or lethargy, the patient enjoys the stimulation derived and continues to use the drug if the physician is not alert in regulating and curbing the supply. Some common tranquilizers are addictive and present withdrawal problems. A number of these drugs potentiate each other and alcohol to the extent that it has become a growing method for suicide—the most used method with women.

- Drug addiction is contagious and epidemic. Users infect others. In Sweden, addicts are doubling in number every 30 months except for one period when the government relaxed restrictions and the number doubled in 12 months.

- Lumping marijuana with other drugs contributes to present legal problems of enforcement. Marijuana does not appear to be physically addictive but creates psychological dependence, although the extent is difficult to gauge. It does not appear to incite the user to violence, as amphetamines often do.

- The number of prescriptions written for minor tranquilizers and barbiturates where not really indicated should concern the medical profession and an all-out effort should be made to reduce unneeded family stockpiles of these medications. Children may be tempted to experiment with drugs found in the family medicine cabinet.

- Not only the patient, but the physician can be addicted, since the physician because of his training and experience is susceptible to the taking of drugs for a troublesome condition. The physician must be sure, in prescribing a tranquilizer, that the patient's anxiety is at a level to warrant the use of a drug. He must be sure to regulate the supply and not continue it indefinitely.

Chairman of the symposium was Jerome Jaffe, M. D., associate professor, Department of Psychiatry, University of Chicago. His major interest is in the use and abuse of psychoactive drugs, particularly the biological and sociological aspects.

One sex could collapse our culture

Why should this country's future be influenced by unisex? Our survival quotient reflects the capacity to adapt; and adaptation mirrors the strength of our feelings of personal identity. Central to anyone's sense of personal identity is his or her awareness of sex. A man with a confused notion of masculinity, and a woman with an uncertain feeling of femininity, is likely to possess a relatively unhealthy and ineffective concept of personal identity. Of the more than 2,000 cultures about which we have some information, every single one of the approximately fifty-five with blurred sex roles and feelings of personal identity collapsed in a few generations.

Man may still propose, God dispose—but history imposes. Perhaps the most significant lesson of the past for our age of unisex is that no culture characterized by a similar blurring has proved viable. (Charles Winick, Ph.D.: *Sex and Society: Unisex in America. Medical Opinion & Review* (Sept.) 1970, pages 62-63, 65.)

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THE VIEW BOX

(Continued from page 508)

DIAGNOSIS: 3. Steak eaters disease

Physiologic narrowing of the esophagus occurs at three points of some clinical significance, particularly in patients who have ingested foreign objects. Coins are likely to stick above the level of the manubrium sterni. Other objects may lodge at the level of the aortic arch or bifurcation of the trachea, where strictures also are particularly likely to form. The third point of physiologic narrowing is located at the diaphragm, where large chunks of meat or other foods may stick and fail to pass—so-called "steak eater's disease." Of incidental interest is a form of treatment using a meat tenderizer. The patient drinks a solution every 10 minutes until the meat fibers dissolve. It seems to be selective for the steak and not for the esophagus. However if you are doubtful about attempting this, the other method of therapy is removal through the esophagoscope. The esophogram was normal after passage of the steak bolus.

Obituaries

***Frederick P. Cowdin**, Springfield, died June 3 at the age of 86. He was past president of the Sangamon County Medical Society and a member of the ISMS Fifty-Year Club.

***William H. Haines**, Chicago, died September 16 at the age of 72. He was director of the Behavior Clinic of the Cook County Criminal Court.

***Joseph G. Kostrubala**, Kenosha, Wisconsin, died September 30 at the age of 67.

***Harold A. Swanberg**, Quincy, died in September at the age of 78. He was a founder of the American Medical Writers Association and a member of the ISMS Fifty-Year Club. He was past president and past secretary of the Adams County Medical Society.

***Earle H. Thomas**, Lake Wales, Fla., died September 16. He was well known throughout the United States for his work in oral surgery and his numerous scientific articles. He was a member of the ISMS Fifty-Year Club.

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BASIC GYNECOLOGY, One Week, November 30
SURGICAL & RADIATION THERAPY OF GYNE. MALIGNANCIES, Nov. 30
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UROLOGY FOR GENERAL PRACTITIONERS, Two Days, Nov. 19
ADVANCES IN MEDICINE, One Week, November 30
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CLINICAL NEUROLOGY, One Week, December 7
RADIOISOTOPES, One or Two Weeks, Request Dates
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Informal Clinical Courses in Subspecialties, Request Dates

Information concerning numerous other continuation courses available upon request.

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Surgical Grand Rounds

(Continued from page 513)

and, especially, for this kind of tumor. She's got a total resection.

Dr. Beal: As I recall, this is one of the tumors in which you were satisfied to remove part of the tumor in order to lessen the morbidity and the mortality.

Dr. Raimondi: This is correct and Dandy's approach to it was simply to gut the tumor; he'd open the capsule and gut the inside and then he'd leave the tumor there because, in taking the tumor out, the mortality and morbidity were, really and truly, prohibitive.

Dr. Beal: So this is another advance by the method that you outlined; that your surgical approach now is one that is more or less complete.

Dr. Raimondi: Without any element of bluster, I think, if you look across the land, you will find that now a postoperative death in an acoustic neurinoma is really looked on with considerable criticism. I suspect if you get a couple of them, then the otologists aren't going to be working with you anymore, because they've got a much better morbidity and mortality coming right through the ear.

Dr. Kerth: The postoperative mortality is still between 5 and 10%, but this is true only for large tumors. We feel that one should attempt complete removal at the time of initial surgery. Doctory Dandy at one time advocated incomplete removal, but a long term follow-up of his patients showed that they frequently came to secondary surgery and the mortality at that time was very high. ◀

Film Reviews

"Diagnosis in Clinical Disorders of Calcium and Bone Metabolism" is a two-part, 16mm, sound film in which parathyroid diseases, including primary hyperparathyroidism, parathyroid dysfunction in renal failure, and hypoparathyroidism are discussed using slides and charts. Both films can be obtained from: National Medical Audio-visual Center (Annex), Station K, Atlanta, Ga. 30324.

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Amid all the clamor about coexisting anxiety and depression,



BLUE SHIELD REPORT



FOR *Illinois Physicians*

BLUE CROSS/BLUE SHIELD APPOINT CONSULTANTS

Blue Cross and Blue Shield have appointed and are training several physicians to serve as professional consultants. They will meet with Utilization Review committees and committee chairmen, to review their procedures and guidelines, evaluate the effectiveness of Utilization Review, and suggest ways to improve when necessary.

Utilization Review committees, urged by Illinois physicians four years before Medicare, became increasingly important with the advent of Medicare because such committees were made a condition of participation for hospitals. They were also required for accreditation by the Joint Commission on Accreditation of Hospitals.

Blue Cross and Blue Shield recognize the responsibilities of Utilization Review committees. But we also know that some function more effectively than others. This may be due to a variety of reasons, many of which we feel can be corrected with professional guidance and assistance.

Representatives of Blue Cross and Blue Shield have continued to work closely with members of the Board of Trustees of the Illinois State Medical Society to find more economical ways to use health services and facilities without additional government intervention. Last year we met with the Board of Trustees and asked their help in appointing consultants to Blue Cross and Blue Shield.

Several physicians expressed a willingness to serve as consultants and to help physicians conduct more effective utilization review in local hospitals.

Dinner Workshops End for Chicago Area

Blue Shield ended its annual series of dinner workshops for medical assistants in the Chicago area on November 19 with our final meeting in the Knickerbocker Hotel. This year, the meetings, held on Wednesday and Thursday nights from late September on, were attended by more than 4,000 medical assistants and other invited guests.

We received many favorable comments on the program, including the slide presentation showing our Blue Shield Plan offices and the steps that are taken in processing Medicare and Blue Shield claims.

We expect that these consultants will be able to increase the efficiency of committees. It is equally important that these reviews remain the responsibility of physicians rather than that of non-professionals.

Physicians interested in learning more about the consultant program may obtain information by writing to:

Morton W. Adler, M.D.
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The physician should not attempt to remedy the situation by himself by forwarding an incorrect payment to the other physician.

Instead, the physician should notify us, in writing, of the error. Our address is:

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Please include the check number, date, patient's name, group and subscriber number and date of service.

If the error is a duplicate payment or payment to the wrong physician, please return the check with your letter.

If the error is an overpayment, we recommend that you keep the check until we determine the amount of the overpayment. However, if you wish, you may return the original check and we will issue you another one.

ASK BLUE SHIELD

• • • ABOUT MEDICARE

Private Clinics and Physician Groups

Medical groups or physicians' clinics which have agreements with individual staff or member physicians to bill for them should use the SSA-1490, Medicare Request for Payment form.

The group should inform us that it will be billing for the physicians, only when it has proper authorization, on file, from each physician.

If charges are uniform for all physicians, services furnished by different physicians for the same patient may be reported on the same SSA-1490 form. In this case, we will assign one physician code number for the group as a whole.

Groups in the five county area of Cook, Kane, Lake, Will and DuPage, wishing to be assigned such a number, should contact Walter Livingston, Director of Professional Relations, or Mrs. Loretta O'Donnell, Professional Relations Representative.

The form should be signed by an authorized representative of the group, who need not be a physician.

Where the charge for a procedure differs depending on the individual physician, the name of the physician should be shown, together with the description of the procedure in Item 7c of the SSA-1490. In this case, individual codes will be used for each physician.

Billing Patients

When You Accept Assignment

Physicians should be reminded that if they accept assignment, they agree to accept the reasonable charge determined by Medicare, and they agree not to bill the patient for more than any remaining deductible and 20 percent of the reasonable charge. Medicare will pay the other 80 percent.

Many times, physicians who have accepted assignment supply their patient with an itemized, non-receipted bill. Then the patient, unknown to the physician, will submit his own separate claim for payment. Since Medicare does not require a receipted bill to pay the patient, it is possible that we will make payment to the patient instead of the doctor.

To avoid this problem, we urge physicians who accept assignment 1) to make sure any bill given to the patient shows clearly that the physician has accepted assignment, or 2) not to send a bill to the patient until after they receive our payment and can show the patient the allowable charges and balance remaining.

MEDICARE: What It Pays For

Physicians and their medical assistants often ask questions about Medicare's coverage. Though it is impossible for us to give you a complete listing here of all services and goods covered by Part B, there are certain general guidelines which should answer most questions physicians have about coverage.

Part B of Medicare will help pay for:

- 1) Medical and surgical services performed by a physician anywhere in the United States, e.g., in the home, hospital, clinic, nursing home, etc.
- 2) Other services ordinarily furnished in the physician's office and included in his bill such as:
 - a) Diagnostic tests and procedures. (If furnished by an independent laboratory, the physician must indicate the name of the lab and all charges made on the SSA-1490 form.),
 - b) Medical supplies,
 - c) Services of his office nurse,
 - d) Drugs and biologicals which cannot be self-administered.

Part B of Medicare will NOT pay for:

- 1) Routine physical checkups (and lab tests related to them),
- 2) Routine foot care and treatment of flat feet, sprains, or partial dislocations,
- 3) Eye refractions and examinations for eyeglasses,
- 4) Hearing examination for hearing aids,
- 5) Immunization (unless directly related to an injury or immediate risk of infection, e.g., anti-tetanus shot given after an injury.
- 6) Papanicolaou tests, unless one of the following conditions has been met:
 - a) Previous cancer of the cervix, uterus or vagina which has already been tested. The "Pap smear" would be for the purpose of follow up care.
 - b) Previous abnormal "Pap smears."
 - c) Irritation or inflammation of the cervix as determined by physical examination.
 - d) Abnormal vaginal discharge or bleeding.

For a more detailed explanation of covered benefits, ask for a copy of the "Physicians Guide to Medicare" available at your local social security office, or if you live in the five county area of Cook, Kane, Lake, Will and DuPage, write to:

Professional Relations Department
Blue Shield Plan of
Illinois Medical Service
222 North Dearborn Street
Chicago, Illinois 60601



J. Ernest Breed

The President's Page

Innovations mark the Annual Meeting

Profound changes are planned for the Annual Meeting of the State Medical Society next May. To begin with, the meeting place has been changed to the Arlington Park Towers Hotel in Arlington Heights.

This beautiful, fourteen story hotel overlooks the Arlington Park race track, a quarter of a mile away, and is surrounded by open spaces. It has a 9 hole, lighted golf course on one side, and ample free parking space on the other. The hotel is easy to reach via the Northwest Toll Road and lies about 10 miles northwest of the O'Hare Airport. A courtesy shuttle bus travels between the airport and the hotel.

Instead of a crowded, noisy, old building, we will be housed in a new, clean exotic hotel with superb facilities, including a night club, theatre, swimming pool and several fine restaurants.

The hotel has ample meeting rooms for our banquets, exhibits and House of Delegates meeting. The sleeping rooms are all air conditioned, roomy and beautifully decorated.

In addition to the regular scientific programs arranged by the specialty societies, there will be 36 small classes of 20 to 30 doctors on many scientific subjects, lasting from 8:30 a.m. to 10:00 a.m. A list of these classes and the professors will soon be sent to you and those who wish to attend must sign up in advance. Credits will be given toward the AMA Continuing Education

Award, and the Academy of Family Practice membership requirements.

There will be a large self-testing section, capable of handling 300 physicians a day, where you may test your knowledge against the computer. You, alone, receive your score. Just for fun, see how you rate.

Our ladies will receive special attention. There will be special programs, luncheons, style shows, theatre parties, even perhaps a golf tournament. There will also be frequent buses to Chicago's Loop and to the well known shopping centers of the northwest and north areas.

One of the chief advantages in having the membership housed in one hotel is that it provides the opportunity to become acquainted with your colleagues from different parts of the state. You will be surprised at how much you have in common.

Visit the House of Delegates and the reference committee meetings, and let your voice be heard. These are trying times for the medical profession, but unless you take part in the deliberations you cannot complain if you don't approve of the actions taken by your Society.

Make your reservations early and come to the Illinois State Medical Society meeting at the Arlington Park Towers Hotel next May.

J. Ernest Breed M.D.

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The FDA considers the advertising misleading in several respects such as:

The *in-vitro* chart contained in the ads, which compared Garamycin Injectable with seven other antibiotics, implied that Garamycin Injectable is clinically more effective than the seven other compared antibiotics. THE FACTS ARE (1) THAT DIRECT EXTRAPOLATION OF NONCLINICAL FINDINGS TO CLINICAL EFFECTIVENESS IS UNWARRANTED, AND (2) THAT THE ADVERTISED *IN-VITRO* COMPARISONS DO NOT CONSTITUTE A VALID BASIS FOR SUGGESTING THAT GARAMYCIN INJECTABLE HAS GREATER CLINICAL EFFECTIVENESS THAN THE COMPARED ANTIBIOTICS.

The *in-vitro* chart and information contained under the ad heading, "Indications" presented *in-vitro* data results in such a way as to imply that the drug is indicated for Gram-positive bacteria, such as *Staphylococcus aureus*. GARAMYCIN INJECTABLE IS NOT APPROVED FOR INFECTIONS DUE TO ANY GRAM-POSITIVE ORGANISMS.

We emphasize that Garamycin Injectable is approved for use only in infections due to susceptible strains of gram-negative bacteria, including *Pseudomonas aeruginosa*, and species of indole-positive and indole-negative *Proteus*, *Escherichia coli*, and *Klebsiella-Aerobacter*.

Abstracts Of Board Actions

Board of Trustees Meeting
October 24-26, 1970
Augustine's, Belleville

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. It covers only major actions and is not intended as a detailed report. Full minutes of the meetings are available upon any member's request to the headquarters office of the ISMS.

Reports of Officers and Others

Reports from the officers covered numerous matters in health care delivery, medical education and manpower, indicating a keen awareness of problems in these areas.

President Breed reported on further negotiations with Dr. George Miller at the University of Illinois College of Medicine, to conduct a self-examination project at the 1971 Annual Meeting. Approximately 300 physicians will be tested on each of three days, with confidential scores expected to reveal to the individuals the extent of his need for refresher training. The Board acted to approve the project in principle and authorized its referral to the Educational and Scientific Foundation for funding after final negotiation on costs.

Dr. Fruin, President-Elect, reported on his attendance at the Annual Meeting of the Illinois Hospital Association at which hospital-based capitation programs of health care delivery received much attention. He expressed concern over the future role of the physician in such programs. Dr. O'Donnell expressed similar concern after attending a meeting in Lincoln at which the local hospital was engaged in plans to create additional hospital-based physicians.

Dr. Jannings, Second Vice-President, spoke of the physician shortage as being the number one concern of downstate rural physicians. He referred to numerous shortcomings of governmental and other health care programs and interferences in the practice of medicine. Dr. Jannings concluded by stating that in his opinion and that of some colleagues, organized medicine has sold out to the Federal government by going along with all that is suggested.

In reporting for the Finance Committee, Dr. Pfeiffenberger, Chairman, indicated that expenditures were in line with income and within the budget as of the September 30 Financial Statement. The 1971 budget will be developed early in December for January presentation to the Board.

Dr. Reisch, Secretary-Treasurer, reported on membership matters and commented upon the Leadership Conference on Health Maintenance Organizations and Foundations for Medical Care, to be held in Chicago on Sunday, November 15. Early indications are that attendance will be very large. He further reported great interest in the physician liability program being presented on the President's Tour.

Dr. Sunderland, Speaker of the House, indicated plans to name Reference Committee appointments for the 1971 Annual Meeting at the time of the January Board meeting. Trustees were asked to assist the county societies to name their delegates at an early date.

Dr. Scrivner, Chairman of the Board, reported on the October 19 meeting between Governor Ogilvie and representatives of the ISMS. A sense of declaration was sought from the Governor as to the administration's goals and plans for health. It was found that the Governor was quite well versed on medical education, delivery of health care, pollution and other matters. The ISMS was invited to continue its input through the usual channels and to seek further conferences with the Governor on problems which needed his immediate attention.

Relative Value Study

A surprising number of requests continue to be received from Illinois physicians for copies of the Illinois Relative Value Study. This booklet, originally developed in the early 1960s and revised slightly in 1963, has been reprinted twice. Improvements and refinements made by the California Medical Association in their RVS recommends its use in preference to the Illinois documents. The Illinois RVS will not be reprinted and members desiring to use a relative value study will be advised to obtain a copy of the new California RVS.

Physician's Assistants

The popularity of establishing, by law, a new category of health worker to be known as a physician's assistant, was noted. The ISMS Committee on Allied Health Education was directed to increase the tempo of its activity in this area, looking toward legislation which would provide some form of recognition of these persons as members of the health team. It is conceived that such persons would be supervised and directed by the physician in accordance with the needs as determined by the physician.

Regional Medical Program

Questions were raised as to whether or not the Illinois Regional Medical Program has lost sight of its original objective for developing programs to combat heart, cancer, stroke, kidney and related diseases, as IRMP appears to have assumed a role in health care delivery which was excluded from the original legislation. The Board authorized appointment of a committee to meet with representatives of IRMP to discuss this matter.

Anti-Substitution Restrictions on Pharmacists

The Illinois Board of Pharmacy, which administers the Illinois Pharmacy Practice Act, recently modified its enforcement rules with respect to substitution of drugs as a cause for revocation of license. Heretofore, a pharmacist jeopardized his license by substituting, without prior approval, when a brand name was specified. The rules now provide that the pharmacist is in jeopardy only when the substitution involves a drug which is "not of therapeutic equivalence."

The American Pharmaceutical Association is on record as favoring repeal of state anti-substitution laws. The Illinois Pharmaceutical Association has not formally acted but plans a meeting next spring to decide whether or not the Association should launch a campaign to abolish the law.

Acting on the recommendation of the Council on Legislation and Public Affairs, the Board of Trustees adopted the concept of

(Continued on page 612)

clear the tract with the

Robitussin® Line

The coughing season is here again. Time to rely on the four Robitussins and Cough Calmers to help clear the lower respiratory tract. All contain glyceryl guaiacolate, the efficient expectorant that works systemically to help increase the output of lower respiratory tract fluid. The enhanced flow of less viscid secretions soothes the tracheobronchial mucosa, promotes ciliary action, and makes thick, inspissated mucus less viscid and easier to raise. Available on your prescription or recommendation.

For coughs of colds and "flu"

Robitussin®

Each 5 cc. contains:

Glyceryl guaiacolate 100.0 mg.
Alcohol, 3.5%

For unproductive allergic coughs

Robitussin A-C®

Each 5 cc. contains:

Glyceryl guaiacolate 100.0 mg.
Pheniramine maleate 7.5 mg.
Codeine phosphate 10.0 mg.
(warning: may be habit forming)
Alcohol, 3.5%

Non-narcotic for 6-8 hr. cough control

Robitussin-DM®

Each 5 cc. contains:

Glyceryl guaiacolate 100.0 mg.
Dextromethorphan
hydrobromide 15.0 mg.
Alcohol, 1.4%

*Clears sinuses and nasal
stuffiness as it relieves cough*

Robitussin-PE®

Each 5 cc. contains:

Glyceryl guaiacolate 100.0 mg.
Phenylephrine hydrochloride 10.0 mg.
Alcohol, 1.4%

*Robitussin-DM in solid form
for "coughs on the go"*

Cough Calmers™












Each Cough Calmer contains:

Glyceryl guaiacolate 50.0 mg.
Dextromethorphan
hydrobromide 7.5 mg.

Select the Robitussin® "Clear-Tract" Formulation That Treats
Your Patient's Individual Coughing Needs:

Robitussin® extra benefit chart

All 5 Robitussins have an EXPECTORANT-DEMULCENT action. Keep this handy chart as a guide in selecting the formula that provides the *extra* benefits you want for your patient.

	Cough Suppressant	Antihistamine	Long-Acting (6-8 hours)	Nasal, Sinus Decongestant	Non-Narcotic
ROBITUSSIN®					
ROBITUSSIN A-C®					
ROBITUSSIN-DM®					
ROBITUSSIN-PE®					
COUGH CALMERS™					

A. H. Robins Company, Richmond, Va. 23220

A·H·ROBINS

Control of hyaline membrane disease

Proved effective by estrogen injections

Injections of sex hormones for premature infants may be the answer to controlling hyaline membrane disease, according to a report in a recent issue of **The Journal of Reproductive Medicine**, published by The University of Chicago.

Treating newborn infants with estrogen already has proved effective in eliminating mortality resulting from this deadly lung disease.

The report was made by Dr. Douglas R. Shanklin of The University of Chicago and Dr. S. L. Wolfson of the University of Florida, Gainesville.

The Journal of Reproductive Medicine is the periodical of the American Academy of Reproductive Medicine.

Dr. Shanklin is Professor of Pathology and of Obstetrics and Gynecology in the Division of the Biological Sciences and The Pritzker School of Medicine at The University of Chicago.

Dr. Wolfson is Clinical Associate in Pediatrics at the University of Florida and Teaching Chief of Pediatrics at Tampa, Florida, General Hospital.

"A possible role for estrogenic substances or a sex hormone factor in the pathogenesis of hyaline membrane disease was derived from the highly significant difference in the incidence of fatal cases between male and female infants," they said.

The researchers found that more male infants than females die from the disease, a deadly pulmonary disorder which affects an infant's lungs and causes asphyxiation when a protein membrane seals off the air sacs. Each year, the disorder claims the lives of more than 25,000 premature and newborn babies.

As a result of their research, Dr. Shanklin and Dr. Wolfson developed the concept that "premature infants lack exposure in time to estrogens and that a large dose might overcome some of the effects of this deprivation."

In clinical trials with infants it was found that there was a reduction to one-third of the clinical syndrome of respiratory distress. Mortality was lessened for males but was essentially unchanged for females, again furthering the interrelationship between the hormone and the sex of the infant.

The clinical trials showed that intramuscular injection in the first 20 minutes of life eliminated all mortality.

"Less benefit followed injection in the interval 21-40 minutes and none at all after 40 minutes after birth."

The physicians call for future trials of the estrogen substance administered at the earliest possible moment following the birth of premature infants and experiments to determine the most effective dose.

ON THE COVER

The dove of peace, in abstract form, graces the cover of the December IMJ—abstract because that is the way the concept of peace appears today, amid a world torn by wars, epidemics and starvation. The Journal staff conveys its "Season's Greetings" to you and presents you with a review of the past year in medicine with George Dunea, M.B., M.R.C.P.'s article, "Hemodialysis 1970," and Cecil G. Sheps, M.P.H. M.D.'s commencement address at the Chicago Medical School.

Lumbar hernia

An instance reported

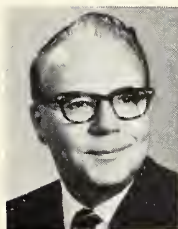
By R. H. MUSICK, M.D. AND STEPHEN E. SCHUBERT, M.D./MENDOTA

We are reporting a patient with a lumbar hernia because of the apparent infrequency of its occurrence. A review of the literature reveals that some 180 cases have been reported. One large New York metropolitan hospital records only two patients with lumbar hernia out of 250,000 consecutive admissions. All authors referred to emphasize that it is a rare type of hernia to encounter in any busy surgical practice.

A majority of the lumbar hernia reported readily fall in one of three groups: (1) congenital; (2) acquired non-traumatic; and (3) acquired traumatic (from injuries or post-surgical). It appears that approximately one-fourth fall in the first group, one-half in the second and one-fourth in the third group.

Although our patient sustained trauma a few months prior to the finding of the hernia, we believe it should be placed in the group of acquired non-traumatic lumbar hernias. We shall try to indicate in the operative findings our reasons for placing it in this classification.

In the lumbar area there are two well-defined areas of potential weakness. One is known as the inferior triangle of Petit. The boundaries of this area are the external oblique muscle anteriorly, the latissimus dorsi posteriorly and the crest of the ileum inferiorly. The second being the superior angle of Grynfelt which has as its boundaries the twelfth rib superiorly, the internal oblique muscle anteriorly and the erector spinae posteriorly.



R. H. Musick, M.D. (left), maintains a private practice in Mendota specializing in general surgery. He received his M.D. from Northwestern University and served his internship and residency at Illinois Central Hospital, Chicago. Stephen E. Schubert, M.D. (right), also does private practice in Mendota. A general practitioner, Dr. Schubert received his M.D. from the University of Illinois Medical School, and interned at Cook County Hospital.



Case Report

The patient was a 71-year-old white woman who presented with a protruding soft mass in the right flank area. She complained of no subjective symptoms. A careful review of the past history reveals only that she has had a moderate systolic and diastolic hypertension for the past ten years, which has been well controlled with hypotensive drugs. She has had no past surgery, or other serious illnesses. This patient was in an automobile accident about six months prior to noting the above finding, at which

and a resulting gurgling sound. This lumbar mass was noted more prominently with the patient in the sitting position and a pulsation and an increase in size noted on coughing or laughing. The routine laboratory procedures showed a normal blood picture and a normal urinalysis. The blood sugar was 106, and the BUN 20. An intravenous pyelogram was obtained showing normal findings with no abnormal position of the right kidney or ureter. A barium enema also revealed normal findings with the exception of the cecum and first part



Fig. 1. Film of right colon showing lateral positioning of this structure into hernial sac.

time she sustained multiple rib fractures and multiple severe contusions on the right side of her body.

The physical examination showed a moderately obese woman appearing younger than her chronological age. A complete physical examination revealed only positive findings referable to the right flank area. As important negative findings it should be noted that there are no abdominal scars, inguinal or umbilical hernia and no palpable organs. Examination of the right lumbar area shows a soft orange size mass easily reduced in size with light pressure

of the ascending colon projecting laterally beyond the subcutaneous fat layer to an extraperitoneal position. (Fig. 1)

This finding from the barium enema gave us the impression of a sliding hernia considering the usual fixation of the cecum and ascending colon to the posterior parietal peritoneum.

The operative procedure was carried out under general anesthesia and the patient placed in the left lateral position. The table was broken to increase the space between the twelfth rib and the crest of the ileum. An oblique incision was made below the

twelfth rib from about the lateral margin of the lumbar muscle to a point just medial to the anterior spine of the ileum. The incision was carried through the skin and subcutaneous fat. An isolated mass of fatty tissue was noted immediately below the subcutaneous fat layer. This was approximately 5-6 cm. in diameter and located just superior to the crest of the ileum. This mass of fatty tissue could easily be reduced into the abdomen through an aperture which readily admitted three fingers. An attempt was made to find a sac by careful sharp and blunt dissection into this protruding fatty mass.

A peritoneal layer was soon encountered and through this we could easily see the movement of a segment of bowel. We elected not to open the peritoneum as the herniation seemed to be readily and completely reduced. This preperitoneal mass of fat was dissected from the margins of the aperture and partially removed. It was noted that good quality transversalis fascial layers were readily available and could be approximated to completely close the hernial opening without undue tension. This was done with the approximation maintained with interrupted 00 silk sutures. The hernial defect appeared to be adequately closed without the need for a flap of fascia lata as described in some operative procedures. Drainage was provided for the subcutaneous space by the hemovac suction and the wound closed by approximating the subcutaneous fat layer with interrupted

plain 00 gut sutures, and the dermal margins with interrupted dermal 00 sutures.

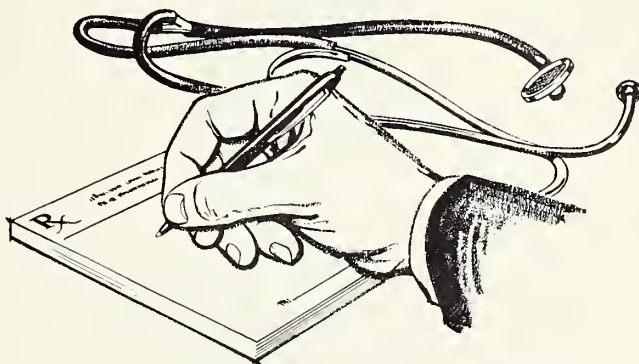
We did not detect any evidence of previously lacerated muscle or scar tissue formation which might be expected from a resolved hematoma. The patient made a good post-operative recovery and observation a few months later indicated the hernia is well contained.

Summary

An instance of a lumbar hernia presenting through Petits triangle is reported. Even though a history of injury was present the findings did not indicate evidence of trauma in this area. Therefore we would classify it as an acquired non-traumatic lumbar hernia presenting through Petits triangle. ◀

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Birthdays, anniversaries, holidays, ISMS annual convention, May 16-19, 1971



BY LEON LOVE, M.D.

*Director, Department of Radiology, Loyola University Hospital
and Chairman, Department of Radiology, Loyola University
Stritch School of Medicine*



Fig. 1



Fig. 2

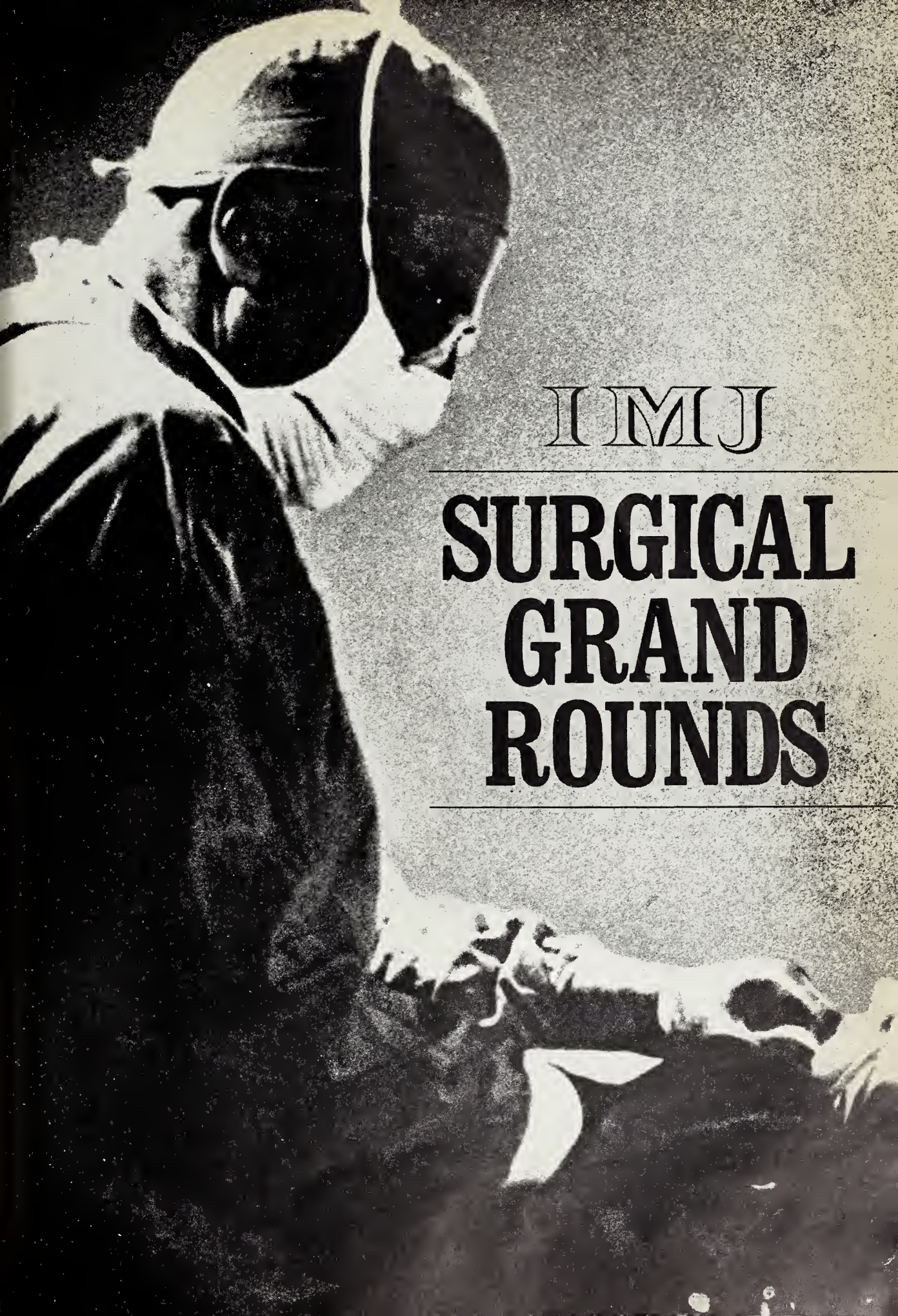


Fig. 3

This 23-year-old patient entered the hospital with a history of backache, loss of weight, night sweats, and fever which was intermittent in character over the past five months. Physical examination revealed fine rales over both upper lung fields. There was some tenderness over the region of the lower dorsal and upper lumbar spine. A PA chest film (Fig. 1) was ordered and because of its appearance, a Bucky chest (Fig. 2) was requested. What's your diagnosis?

1. Lymphangitic spread of a carcinoma
2. Histoplasmosis
3. Tuberculosis
4. Sarcoidosis

(Answer on page 639)



IMJ

**SURGICAL
GRAND
ROUNDS**

Surgical Grand Rounds are held weekly on Saturday at 8:00 a.m. in the Offield Auditorium at Passavant Memorial Hospital. Patient presentations from Passavant, Chicago Wesley Memorial and the Veterans Administration Research Hospitals form the usual basis of the discussions. This case report was part of the Surgical Grand Rounds of February 28, 1970, where a patient from Children's Memorial Hospital was presented.

Mid-gut volvulus with malrotation



Fig. 1. Plain film of the abdomen shows multiple distended loops of small bowel.

EDITED BY JOHN M. BEAL, M.D./CHICAGO

Case Report:

Dr. Robert S. Huebner: On January 31, 1970 a seven-week-old, white, male infant, whose medical history had begun on the third day of life when he began to have intermittent bilious vomiting and progressive abdominal distention, was admitted to the Children's Memorial Hospital. X-rays were taken at that time. The upper G.I. series was interpreted as essentially normal; however, the barium enema was said to show malrotation of the colon. The child continued to vomit. He was subjected to operation on the fifth day of life, and malrotation of the colon was found with transduodenal constricting bands. Mid-gut volvulus was reported to be present and was corrected. The constricting bands were cut and the patient improved during the subsequent three weeks. He gained weight slowly and was sent home.

Two weeks later, he was brought back to the same hospital with a temperature of 101°, marked abdominal distention, vomiting and bloody diarrhea. Roentgenograms

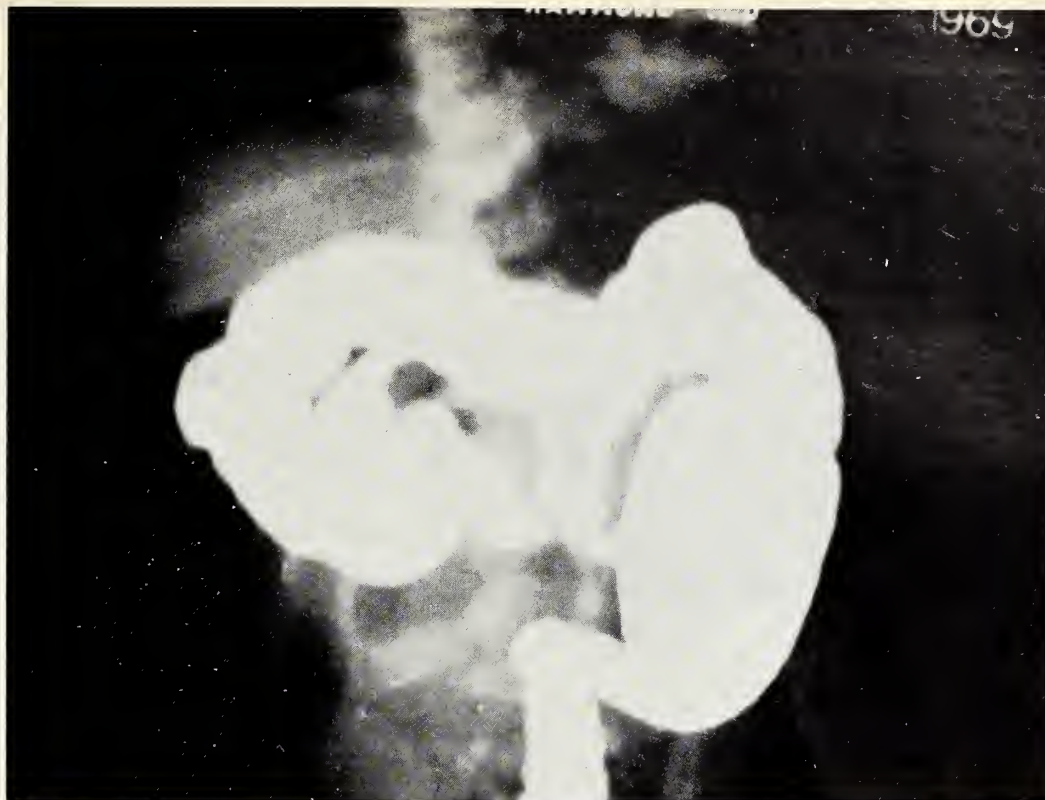


Fig. 2. Radiologic study of the colon does not demonstrate obstruction but the cecum is abnormally high.

were reported to demonstrate partial obstruction at the duodenal-jejunal junction with a leak into the peritoneal cavity. He was operated upon, and almost complete necrosis of the mid-gut was found. At that time, more than 40 cm. of jejunum and ileum were resected. There was diffuse intraperitoneal sepsis with several abscesses. After a period of five days, when feeding of glucose water was instituted, bile-stained drainage appeared in the mid-portion of his abdominal wound. Radiologic study showed a fistula arising from the level of the duodenal-ileal anastomosis. He was transferred to Children's Memorial Hospital for further therapy.

When admitted, he was well hydrated; serum electrolytes were within normal limits. An external jugular-superior vena cava hyperalimentation feeding catheter was inserted and feedings begun. He started to gain weight at the rate of 10 to 60 grams per day and the fistula closed after two days. However, he began to vomit bile stained material, which suggested obstruction at the level of the fistula and anastomosis. After X-ray study, an operation was again performed. At this time, a dilated duodenum was found proximal to the previous anastomosis. About 1 cm. distal to the duodeno-

ileal anastomosis, there was complete necrosis of the small bowel extending to the cecum. An anastomosis of the duodenum to the cecum was performed. At the present time, the child continues to improve. He is vigorous, healthy, and gaining weight again, although he only has approximately 10 cm. of small bowel.

Dr. Abram H. Cannon: These are the plain film studies of the abdomen that were made initially, showing multiple distended loops of small bowel, brought out best on the erect film. (Fig. 1) The multiple fluid levels within the small bowel indicate a small bowel obstruction. A colon study done at this time reveals no obstruction of the colon. The cecum occupies a very high position, suggesting some malrotation is present. (Fig. 2) The stomach study was done about the same time as the colon study and shows that the stomach, duodenum and small bowel are normal. (Fig. 3)

After an operation, the child returned with clinical symptoms of a small bowel obstruction. A film of the abdomen at this time has non-specific findings. There are some dilated loops of small bowel which, with the clinical findings, suggest a small bowel obstruction.

This gastrographin study shows the



Fig. 3. X-rays of the upper gastrointestinal tract are not remarkable.

stomach filled with the gastrographin. There is a fistula in the region of the anastomosis (Fig. 4) that was previously performed, with the fistula apparently right at the anastomotic site.

Dr. Julius Conn, Jr.: Is that first and second film the usual picture of a volvulus with a closed loop obstruction?

Dr. Cannon: I couldn't diagnose that from these films. All I can say is that there is a small bowel obstruction. Usually, with a closed loop obstruction, a greatly dilated loop of bowel will be seen.

Dr. Joseph O. Sherman: Perhaps the best way to discuss this case is to initially talk about malrotation and then about this child in particular.

During embryonic development there is a concomitant counter-clockwise rotation of the duodenal-jejunal loop and the cecum around the superior mesenteric artery.

In the 5 mm. embryo, the stomach, duodenum, small bowel and colon are all ventral to the superior mesenteric artery. Rotation of the duodenal-jejunal loop places the duodenal-jejunal junction in its normal position in the left upper quadrant in the 40 mm. embryo. This rotation can stop at any point between the original ventral position and the left upper quadrant. Thus, the duodenal-jejunal loop can be located entirely on the right side or any place between the RUQ and the LUQ. The importance of this is that with the duodenal-jejunal loop located entirely to the right of the superior mesenteric artery, we have growth and elongation of the proximal

small bowel with kinking which can produce obstruction. Secondly, the rotation of the duodenal-jejunal loop brings the proximal mesentery to the LUQ so that it has a broad attachment from the LUQ down across the retroperitoneal area to the RLQ. This broad attachment minimizes the chance of midgut volvulus. Among patients with malrotation, the mesentery is attached retroperitoneally by a narrow stalk at the point of origin of the superior mesenteric artery.

At the same time the duodenal-jejunal loop is attaining its normal location, the cecum is also rotating around the superior mesenteric artery. Here again the cecum is rotating counter-clockwise around the superior mesentery to reach its normal location in the RLQ. In most cases of malrotation the cecum is usually located in the LUQ or the RUQ. Failure of complete rotation of the cecum to the RLQ results in the formation of fibrous adhesions, Ladd's bands, from the cecum across the duodenum to the RUQ. These bands can produce partial or complete duodenal obstruction.



Fig. 4. Gastrographin study demonstrates a fistula in the region of the anastomosis.

So we have some kinking of the duodenal-jejunal loop because of elongation and failure of rotation, inadequate attachment of the mesentery and a beautiful set-up for midgut volvulus and Ladd's bands from the

cecum to the RUQ. In addition, 10% of these patients have an intrinsic obstruction of the duodenum.

These children usually present during the first five days of life with a high bowel obstruction. Occasionally they present in later life with minimal obstruction. If there is a high degree of duodenal obstruction, we see the typical double bubble picture of duodenal obstruction in supine and upright X-rays of the abdomen.

Normally, these children have bile-stained vomiting and minimal abdominal distention. The presence of bloody stools is a very poor prognostic sign because it suggests a concomitant mid-gut volvulus.

Immediately after admission, this patient was started on parenteral hyperalimentation. We infuse a mixture of 3% Aminosol and 20% glucose with added electrolytes and vitamins. We place the infusion catheter in the superior vena cava and maintain a constant flow by using an IVAC 400 peristaltic pump. In addition, a Millipore filter is placed in the IV tubing to reduce the chances of infusing any bacteria, yeast or particulate matter which might be present in the bottle of hyperalimentation solution.

Initially the child was draining 40 to 50 ml. per day of bile from the wound. This fistula closed two or three days after starting hyperalimentation. Preoperatively the patient received parenteral hyperalimentation for one month and gained one pound and four ounces.

We approached him this time through a transverse left upper abdominal incision. We found complete atresia of the small bowel beginning 1-2 cm. distal to the anastomosis. The only thing I could do at surgery was to anastomose the duodenum or little bit of jejunum to the cecum. There was no ileocecal valve or ileum present.

Normally, we treat a malrotation by reducing the mid-gut volvulus, usually with a counter-clockwise rotation of the bowel. Next, we cut the bands across the duodenum. We attempt an appendectomy if the child is in good shape because with the cecum located in the right upper or left upper quadrant, it might be difficult to make a diagnosis of appendicitis in later life. We very carefully pass a catheter through the entire duodenum and jejunum to make sure there is no intrinsic obstruction, and we also straighten out the duo-

denum and make sure there are no kinks, which are also common and can produce obstruction.

Right now, we have a bit of a problem with this infant. The child is going to gain as long as he is on hyperalimentation. We had one child with 25 cm. of bowel which survived and is doing well. I think the record for survival in a patient with the short bowel syndrome is around 15 or 20 cm. I don't think anyone has ever lived with less than that amount of small bowel.

Dr. William Donnellan: This case emphasizes the need for intestinal transplantation. What progress has been made in this field?

Dr. Stuart Poticha: Hyperalimentation can also be used to prepare a patient for an intestinal transplant. The first intestinal transplant was performed in 1967 by Dr. Richard Lillehei. The patient was a 47-year-old woman who suffered a mesenteric venous thrombosis with an infarction of her entire small bowel. This was resected and the patient was placed on hyperalimentation for a few weeks, at which time she received an intestinal transplant consisting of the entire small bowel and right colon. Unfortunately, the patient died 12 hours after the operation from a pulmonary embolus. Since then, there have been at least two other unsuccessful attempts to transplant the intestine in humans. With such rapid advancements in the field of transplantation, successful intestinal transplants may very well be possible in the near future. Hyperalimentation can provide us with a means of supporting an intestinal cripple until his intestinal tract can be restored.

Dr. Conn: What's the significance of the Millipore filter?

Dr. Sherman: The mean diameter of the pores is 0.22 microns and no bacterium can pass through them. The solution we use is an excellent culture media, especially for *Candida albicans*. Since we have to mix the solution ourselves, we are worried about contamination and we do know that we can minimize the chances of passing contaminants from the solution into the baby with this filter.

Dr. Conn: Do you use heparin in your solution?

Dr. Sherman: We do not use heparin, although this had been advocated by some investigators.

(Continued on page 617)

The first hemodialysis program for treatment of patients with end-stage renal failure was established in Seattle ten years ago. There followed a period of vigorous expansion, and gradually, an increasing number of patients was treated with the artificial kidney. Today over 3,500 patients are maintained by chronic dialysis programs located throughout the country; of these, approximately 250 are treated in Illinois.

Hemodialysis represents both a miracle and compromise. A miracle because it has given life where death would otherwise have been inevitable; a compromise because it remains an imperfect mode of therapy. Its very existence emphasizes our impotence in the face of diseases which we can neither prevent nor cure. Yet as we enter a new decade, hemodialysis and renal transplantation remain the only hope for most patients afflicted with renal failure.

Hemodialysis

1970

BY GEORGE DUNEA, M.B., M.R.C.P./CHICAGO

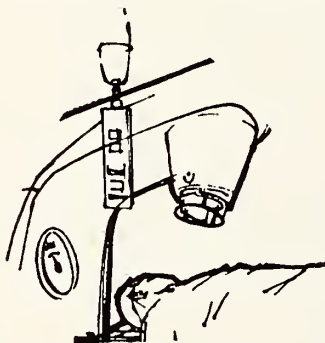
Equipment

The principle of the artificial kidney is simple and many different types have been proposed in the last quarter of a century. Yet few are commercially available, and the choice is limited to a handful of plate or coil dialyzers.

Plate dialyzers are popular with many centers because they are safe, inexpensive, require little blood for priming and allow for a smooth dialysis. Coil dialyzers offer the advantage of convenience, ease of assembly and high efficiency. With the development of better coil dialyzers, wastage of blood has ceased to be a problem. A blood pump is now usually required for all types of dialyzers because of the increased use of the internal subcutaneous fistula.

Two main types of coil dialyzers are

Medical Progress



HARVEY KRAVITZ, M.D.
Medical Progress Editor

used at the present time: the Ultra-Flo* models, which are improved versions of the original Twin-Coil;* and the EX-Dialyzer Cartridges,** which employ a single, rather than a double blood channel. The recently developed EX-03 Dialyzer Cartridge^{1**} is easy to use, effective and removes more water than the earlier EX-01.^{2**} Its characteristics are summarized in Table I. At the end of dialysis the blood is easily returned to the patient. If desired, the coil can be reused several times by storing it in a refrigerator or in saturated salt solution. A procedure for reusing coils has recently been described in detail.³

Table I—The EX-03 Dialyzer cartridge

Volume	200-280 ml.
Membrane	18 micron thick cuprophan
Dialyzing area	0.84 m²
Urea dialysance	134 ml/min (flow rate of 200) 166 ml/min (flow rate of 300)
% Urea reduction (6 hrs.)—abt.	70%
% Creatinine reduction (6 hrs.)—abt.	60%
Average ultrafiltration (6 hrs.)—	2.5Kg
Maximal ultrafiltration (6 hrs.)—	5 Kg

A variety of dialysis systems are in use throughout the country. Multiple delivery systems have been installed in some large centers and are convenient for dialysis of large numbers of patients. Single units have the advantage of flexibility and are more suitable for smaller units and for training patients for home dialysis. These systems vary in size, construction, number of safety devices and cost. Disposable coils may be used in an inexpensive domestic washing-machine^{2,4} or in a standard Travenol Tank.* The more elaborate Recirculating-Single-Pass (RSP)* machine is more convenient but also more expensive. Unfortunately it cannot be adapted for simultaneous use for two patients.

Although the last decade has brought no major breakthrough in technology, numerous advances have contributed to make dialysis safer, simpler and more convenient. New membrane materials such as cuprophane and better membrane supports have allowed the construction of effective dialyzers with low priming volumes. A variety of safety devices such as blood leak detectors and positive-negative pressure gauges have become available. The develop-

ment of commercially manufactured dialysate concentrates has minimized the possibility of error in preparing the dialysis bath. The new all-silastic arteriovenous shunts are an improvement over earlier models because they have neither metal crimp rings nor multiple connecting pieces. New roller blood pumps have become available, replacing the older, noisy, finger pumps.

Increasing clinical experience has done away with the need for numerous laboratory tests. Schedules for heparin administration have been simplified. The need for more frequent dialysis and proper nutrition has become increasingly recognized. The reduction in blood transfusion requirements has lowered costs and decreased the risk of hepatitis. Some patients have never received a blood transfusion and yet have hematocrit levels of 20-24%; others feel well and are able to work with hematocrits of 14-16%.

Acute Dialysis

The interest in chronic renal failure has overshadowed the problems. Moreover, the prophylactic use of mannitol and adequate hydration of the surgical patient has led to a genuine reduction in the incidence of acute renal failure. Yet "acute tubular necrosis" remains a serious problem and the mortality is still too high.

Some patients may be treated adequately by conservative methods but others require dialysis. Most can be treated equally well by peritoneal or hemodialysis and the choice may depend on available facilities, technical factors or the preference of the physician. However, hemodialysis is generally needed in the severely ill, hypercatabolic patient who may have had infection, trauma, surgery or intra-abdominal problems. Here the mortality rate is 70-90%, death being usually the result of the underlying condition. Only by early referral and vigorous, preferably daily, hemodialysis, can there be any hope of reducing this high mortality rate.

Acute hemodialysis is a difficult procedure and is best done by an experienced team. Some patients are extremely ill and only meticulous attention to detail will avoid accidents. A physician should be in attendance and constant monitoring is a wise precaution. Blood should be available

*Travenol Laboratories, Morton Grove, Illinois

**Extracorporeal Medical Specialties, Mt. Laurel Township, New Jersey

and a respirator may be needed. The possibility of digitalis intoxication should be borne in mind and the potassium concentration in the dialysis bath may need adjustment. There is a risk of vomitus aspiration and a suction apparatus should always be on hand. The stomach may have to be emptied by tube and tracheal intubation, or tracheostomy may be necessary. Fluid balance may be complicated by excessive gastrointestinal losses. Regional heparinisation may be indicated if there is a bleeding tendency. Yet, even with all these precautions, the mortality of the severely ill patients with acute renal failure remains too high.

Maintenance dialysis

Currently of the 3,500 patients now being treated in the United States by maintenance dialysis, many are dialyzed in hospitals, but an increasing number have been moved into the home or into satellite units. It has been estimated that approximately 25 new patients per million of population will require treatment every year.⁵ Only the increased use of home dialysis or renal transplantation will avoid the eventual saturation of hospital facilities. Yet renal transplantation remains restricted, by the limited supply of cadaver kidney donors and home dialysis is not always feasible. Even more difficult is the problem of the indigent, often severely hypertensive patient who may be unsuitable for both transplantation and home dialysis.

Many chronic dialysis patients have been rehabilitated and have returned to work. Yet their life always remains uncertain and the mortality rate exceeds 10% per year.⁵ An increasing number of complications have been described, some technical, others medical. They may affect every system of the body. (Table II)

With increasing experience, the incidence and severity of many complications has been reduced. The risk of hepatitis has been lessened by decreased blood transfu-

sion requirements. Weakness, malaise and general ill-health can be avoided by adequate dialysis and good nutrition. Early use of dialysis in chronic renal failure may prevent the development of severe clinical peripheral neuropathy.

Table II—Complications with hemodialyses

1. **Technical:** Membrane rupture, clotting in the coil, leakage from connections, air embolism, wrongly prepared dialysate; copper, calcium or magnesium intoxication; acidosis, hyperglycemia, relative hypoglycemia, hypotension, bleeding from heparin
2. **Av shunt:** Clotting, bleeding, infection, extrusion
3. **Vascular:** Hypertension, hypotension
4. **Cardiac:** Heart failure, pericarditis, arrhythmias, endocarditis, ? myocardiopathy
5. **Neurological:** Dysequilibrium, strokes, convulsions, neuropathy, subdural hematoma
6. **Pulmonary:** Septic emboli, uremic pleuritis, effusions, pulmonary edema
7. **Blood:** Anemia, neutropenia, thrombocytopenia, bleeding, anticoagulation rebound, hemosiderosis
8. **Gastrointestinal:** Hepatitis, hematemesis
9. **Psychological:** Anxiety, depression, psychosis, suicide
10. **Skin:** Pruritus, pigmentation
11. **Locomotor:** Osteodystrophy, arthritis
12. **Endocrine:** Sterility, amenorrhea, gynecomastia

The most troublesome complications are related to the arteriovenous shunt, hypertension and renal bone disease. Clotting and infection of the arteriovenous shunt are frequent and extrusion or bleeding may also occur. This has led to the increased use of the Brescia-Cimino internal arteriovenous fistula which despite its obvious disadvantages, offers a less complicated course than the external shunt.⁵

Hypertension and its effects on the heart and brain probably constitutes the commonest cause of death in patients maintained by chronic dialysis. The need for adequate control of hypertension cannot be overemphasized, and bilateral nephrectomy should be considered if fluid restriction and antihypertensive therapy prove ineffectual. Renal osteodystrophy remains a distressing complication of maintenance dialysis. Symptoms usually appear in the second or third year of dialysis and may include fractures of the ribs or femur. The pathogenesis is poorly understood and the means of prevention are by no means agreed upon. Promising results have been reported with the use of dihydrotachysterol.⁷



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Dialysis in Illinois

The high cost of dialysis remains a major obstacle to its wider use. Many patients with chronic renal failure have been denied treatment for the simple reason that they could not pay for it. Only by a co-operative effort between public and private agencies can hemodialysis be brought to those who need it. In this respect the State of Illinois, by its enlightened attitudes and legislation, has been a pioneer in the field.

In 1967, the Illinois General Assembly passed a bill which provided for an appropriation of one million dollars for the biennium to the Department of Public Health for direct care of patients suffering from terminal renal failure. The Bill also called for the appointment of an 11-man Advisory Committee to assist in the establishment of such a program. The administration of the program was assigned to the Bureau of Chronic Illness of the Division of Health Care Facilities and Chronic Illness. Medical criteria for patient selection and standards for institutional participation were developed by a medical subcommittee of the Advisory Committee. Financial eligibility requirements for acceptance and for patient sharing in the cost of medical care were established by another subcommittee. A system of cooperation between the Departments of Public Health, Public Aid and Vocational Rehabilitation was worked out. Under this system medical referrals for dialysis are routed through the Department of Public Health for approval. The Department of Public Aid pays for dialysis for patients eligible for public assistance. The Division of Vocational Rehabilitation supplies artificial kidney machines on a limited basis. A cost of \$200 per dialysis was initially agreed upon. Later this was reduced to \$180 for institutional dialysis, \$90 for home dialysis and \$220 per dialysis for home training.

Criteria for eligibility have been modified from time to time. In general, selection of patients has been limited to candidates between the ages of 18-60 years who were clinically free from other life-threatening disease, showed an adequate degree of understanding, motivation and emotional stability, and were considered potentially capable of rehabilitation. It was felt that patients should not have disabling clinical problems such as listed in Table III. However, candidates were considered on their

own merits and many exceptions were made.

The first patient was accepted to the program on March 15, 1968. As of August 1970, there were 197 patients being treated in approximately 20 centers or units, some outside Illinois. (To this must be added approximately 65 patients treated in Veterans' Hospitals in Illinois.)

Table III—Contraindications to maintenance dialysis (relative)

1. Coronary artery disease
2. Liver disease
3. Chronic progressive neurological disease
4. Chronic pulmonary disease
5. Irreversible heart disease
6. Malignant disease within five years
7. Severe organic gastrointestinal disease
8. Essential (primary) malignant hypertension with severe and organ involvement
9. Diabetes mellitus with generalized angio-neuropathy
10. Systemic lupus erythematosus
11. Scleroderma
12. Amyloidosis
13. Polyarteritis Nodosa
14. Rapidly progressive, disabling uremic neuropathy
15. Severe psychiatric disorders

This program has played a major role in the development of chronic dialysis facilities in the state. Many states have patterned legislation after that adopted in Illinois.

Conclusion

A small but increasing number of patients with end-stage renal failure has been given a new lease on life by the artificial kidney. At present, facilities remain restricted, the cost high and the clinical results variable. Yet the success of such a program must not be measured only in terms of immediate results. The increasing use of dialysis has added to our understanding of renal disease and stimulated research into medical and technological problems. It has resulted in enlightened cooperative approaches by government departments and private agencies. The expanding market has provided the incentive for industry to innovate, support research and manufacture new products.

It is not too much to hope that the future will bring new methods to prevent and cure renal disease or at least, a better understanding of the pathogenesis of the uremic state. One may also be sure that technologi-

(Continued on page 632)

This is, of course, a day which belongs to the graduates. It marks a turning point in their career of learning and service. In medicine, one faces a lifetime of learning and a lifetime of service. A great deal is expected of medicine these days and physicians are very much in demand.

It is generally recognized now that medical care should be available to all people, regardless of their ability to pay, bringing the best quality of care to them when they need it. However, it is also recognized by all that our health services are in a state of crisis. There probably has never been a time in our history when so many people have been looking so questioningly at our health services system. The discontent stems from the human relations aspect of the medical care services which many individuals receive, from the unavailability of adequate care for certain sections of our population, the short supply of personnel and certain types of facilities, and from the problems of financing comprehensive care for our population.

The medical the and medical

BY CECIL G. SHEPS, M.D., M.P.H.

*Commencement address at the Chicago Medical School/
University of Health Sciences, June 13, 1970.*

We recognize now, more than ever before, that medical science is inseparable from the community and society, and that our task is to address ourselves more directly to the problems of the application of science to the needs of man and the needs of society. This means that medicine and science must face a deeper involvement with society and social problems.

The depth of concern and commitment of today's students is probably unparalleled in the history of our country. I, for one, welcome this enthusiastically. It is our last best hope!

It is understandable that the uneven appreciation of the depth and nature of our problems as a society, not to mention the slow and halting progress towards their solution, should produce frustration and unrest. As Dr. Leon Eisenberg, professor of psychiatry at Harvard Medical School recently has said,¹ "To label unrest as 'sick' is no more than a sophisticated version of the rage of adults at the effrontery of the child who pointed out that the Em-

peror had no clothes on. In part, adult fury stems from the very accuracy of the charge the young lodge against us. This is not to say that the correctness of the accusation warrants abject surrender by our generation; the young have no greater wisdom than we possess, and a good deal less practicality."

The deep emotion of our youth today over our problems is a crucial and essential ingredient for dealing with these problems successfully. These strong feelings reflect a commitment to a new value system which puts human values above all else. Facts are given relevance by the depth and consistency of attention we give to them. The most useless knowledge is the knowledge that is not put to use.

It is our value system, as it actually operates, which is now being so seriously questioned—and so it should be. As Professor Eisenberg says, "The energy, idealism, and intelligence of youth are the prime resources of each nation . . . youth is impatient—as it should be—with excuses for per-

student public care

petuating evil." Sincere feeling, deep concern, and strong commitment are essential conditions for a successful attack on the problems that face us. They are, however, not enough. They provide a fundamental basis for action and progress. Professional and technical knowledge must be harnessed to the value-judgment which impells us to solve the problems of our society. This applies whether we are talking of poverty, racial discrimination, education or health.

The urgent agenda of severe problems that faces our nation is complex and agonizing. Demanding attention, it includes the rapid termination of the war in which we are now engaged, the development of a stable peace, dealing effectively with the problems of race, improving and protecting our biological and physical environment, providing adequate housing, and improving the accessibility and quality of educational opportunity and health services for all people. At the root of all of this is the extent of our dedication to human values, not simply in our rhetoric, but in our actions as a nation. In the field of

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health, we must maintain our research effort, increase the number and quality of health personnel, and improve the system of delivery of health services.

Ten years ago, at a special institute organized by the Association of American Medical Colleges on the interactions between medical education and medical care, I concluded the opening presentation by saying:²

"I believe that medical education has a contribution to make that no other force in our society can make as well in its stead. This is clearly and predominantly the challenge to medical education—to discover, through research, new ways of applying what we know in order to reduce the lag between development of new knowledge and application of it for maximum social purpose. To achieve this end, medical education must reach beyond its usual subject matter. We must acquire new concepts, cultivate new fields, as well as till the old and familiar ones in different ways."

Now, a decade later, I would strengthen this statement by pointing to two factors of great importance—one is the role of the student and the other is the role of the public, the consumer. The expressed concern of medical students has alerted their professors to the fact that they must give attention to the quality and scope of the delivery of medical care. The vigor of student interest has been crucial in producing the start that has been made in a few medical schools to relate themselves directly to improving the delivery of health services to the people they serve and ought to be serving, and to involve students in these activities as a framework for their education.

The classic referral medical center is inadequate as the sole framework for the preparation of physicians of the future. If our new physicians are to be not only scientific but also humane, socially responsible and maximally effective, new models of primary and comprehensive health services to the community must be added to the opportunities offered to medical students as a context for their educational preparation. While recognizing that a start is being made, I say to students and young physicians, let us not be satisfied with small mercies. The continued interest of medical students and graduates calling for such changes in the system of medical education is a vital ingredient in assuring that fur-

ther progress will be made.

Nine years ago, in analyzing the effect of medical care insurance programs for the readers of the *New England Journal of Medicine*, a colleague and I concluded by saying:³

"There can be little doubt that the public will remain earnest and vigorous in its efforts to make sure that medical care of good quality is readily available to everyone. . . . It remains for the medical profession to exercise its best wisdom so that medical care can be rendered under conditions that are most conducive to the highest standard of professional service. This requires innovation and experiment. It also bespeaks the closest possible identification of medicine with the public in delineating needs and goals, and developing effective and efficient programs."

Now, almost a decade later, I would add that without unrelenting demands from the public, the medical profession will not make its best contribution. Why is this so? The answer is disarmingly simple. It lies in the very success and rewarding character of medical service these days. A physician can work hard all day doing his best for the patients who have access to him—and do them a lot of good.

At the end of the day, he naturally believes that he has spent his day in the most effective way. This may not be, and often is not, the case. Too often the patients who do not have access to him, and the health problems he does not tackle, are of much greater importance to the community. With a few notable exceptions in certain organized programs, the physician does not function in a framework which enables him to plan his work so as to prevent and treat the most severe health problems of his community. As a solo private entrepreneur, he may indeed be very busy, using his professional and technical skills in helping patients who come to him. The value of this to the health and welfare of his community is, however, often much less than it would be if his work were focused in a planned purposeful manner upon those health problems in which his special knowledge and skills can best be used to enhance, protect and restore the health of those in the community who are most vulnerable, most in need and most susceptible to these ministrations. That's not the system we have now. What we have has been called a non-system, the last of the cottage industries.

The federal government has recently proposed some action which could, I believe, serve to re-orient the delivery of health services. This calls for the development of a new option in Medicare for comprehensive health maintenance services. Eligible individuals would have a choice of a different type of coverage—the current Part A (for hospitalization) and Part B (for physician services) plus a new Part C which would guarantee on the part of the provider (a health maintenance organization) that “. . . all services under Parts A and B of Medicare plus preventive services will be available . . .” on the basis of “. . . payment of a fixed annual sum negotiated in advance. . . .” It is contemplated that the health maintenance organization would bring together, in a planned program, the health care resources necessary to the patient rather than the current arrangement where, in the main, the individual must seek each kind of care separately. The government believes that the best interests of the nation would be served by diversity and competition among health maintenance organizations and other providers. In addition, this means that the health services delivery group undertaking such responsibilities will be able to plan for the protection and restoration of the health of those patients who are covered by this arrangement.

This proposal is not an idealistic impractical dream. Already, the Kaiser Permanente Groups and similar programs of prepaid group practice are providing comprehensive planned health services for four million people. Stimulating such developments in many parts of the country, which this legislation would foster, will produce a healthy pluralism in our health services delivery system and real choices for the American people.

Twenty years ago, tax funds were used to pay for 25% of all expenditures for health and medical care. By 1966, it had increased only to 26%. By 1969, it had risen to 37%. Greater use of tax funds for essential services is inevitable, and in my opinion, necessary and wise. With it will come greater accountability to the public. The public will want to know what is being done to provide health services that meet the twin objectives of effectiveness and economy. And it will want to be certain that the needs of our underprivileged people in the ghettos and rural areas are being met. In

the ghetto areas of the large cities of our nation, neighborhood people, alienated by the lack of interest in the health problems which plague them most, frustrated by the lack of services, have learned to exert public pressure in order to force the hospitals in their community to modify their services appropriately—for example, to provide prenatal care, to develop adequate emergency room services, to find and treat lead poisoning and to treat narcotic addiction. The protests in our cities, the pickets, demonstrations and sit-ins have highlighted this need and heightened the appreciation of those who now control these services that effective accommodations must be made to the perceptions, interests and needs of the people.

A new kind of partnership is needed in the development and operation of our health services. This partnership would bring the needs and interests of consumers into the decision making structure—not to interfere with professional and technical matters, but rather to help focus their emphasis and maximize their effectiveness in terms of community needs. The people whose lives and welfare are dependent upon local institutions and programs should control the policies of these institutions. This creates a new situation for the health professions. We must learn how to do this enthusiastically, confidently and well.

I have referred to some elements of progress and change that are needed in our health services system. There are others, such as regionalization and improved methods of financing, about which a good bit is already known. The challenge which we face is not so much one of discovering the principles that need to be implemented, but rather of learning how to take effective action to implement the already well-recognized principles of teamwork, regionalization, and the primacy of prevention. Physicians have a fundamental role to play in this and they have, in many ways, the best opportunity.

I've mentioned social values. We need to reach a higher moral ground if we are going to move ahead decisively in dealing with the problems which are dividing our society. Physicians have a special role to play in getting us to this higher moral ground—and a special opportunity—because of their continuous exposure to the agonizing toll of illness and premature death, and the priceless value of health, vigor, and happiness.

In May, the deans of fifteen medical schools sent a telegram to President Nixon, in which they said, "Medical students committed to a lifetime of service in the preservation of health are particularly appalled by the destruction of life in war. The Cambodian invasion has stirred deep frustration and unrest in our own students which we share. We implore you to take unequivocal actions to demonstrate your determination and to end the war quickly without extension of misery to military and civilian populations." This, I submit, is a relevant expression of the higher moral ground to which physicians can be expected to rally—the concern for human life.

Hawthorne has said, "The world owes its onward impulses to men who are ill at ease." I urge you to continue to be uneasy and dissatisfied. Do not allow your absorption with the technical aspects of your day-to-day service to individual patients obscure your view of what remains to be done. Do not lose sight of our urgent agenda.

May I remind you of the statement made by Louis Pasteur at the opening of the Pasteur Institute in Paris in 1888, "Two opposing laws seem to be now in contest. The one, a law of blood and death, opening out each day new modes of destruction, forces nations to be always ready for battle. The other, a law of peace, work and health, whose only aim is to deliver man from the calamities which beset him. The one seeks violent conquest, the other the relief of mankind. Which of these two laws will prevail, God only knows."

I urge each of you to dedicate yourselves, as individuals and as a profession to the law of peace, work and health . . . to help deliver man from the calamities which beset him. I urge this because it is said that when young men have courage, the dreams of old men come true. ◀

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This is the second and last article based upon statistics collected by means of a questionnaire sent to the 5,000 medical students, interns and residents presently training in Illinois. The purpose was to discover what our doctors in training are going to do and if they plan to stay in Illinois. In the first article, I reported that two-thirds of those in training have come from Illinois, but only 30% plan to practice in this state. Over one-third of those who plan to stay in Illinois plan to go outside of Cook County.

The first statistics quoted present the answers to the question:

The plans of our doctors in training

Second article

BY J. ERNEST BREED, M.D., ISMS PRESIDENT

594 Students			
Do you plan to specialize in family practice?	Yes	No	No answer
	82	38	144
	(13.6%)		
Other specialties	330		
	(55.5%)		
252 Interns			
Do you plan to specialize in family practice?	Yes	No	No answer
	14	2	55
	(5.5%)		
Other specialties	181		
	(72.0%)		
550 Residents			
Do you plan to specialize in family practice?	Yes	No	No answer
	8	174	4
	(1.0%)		
Other specialties	364		
	(66.0%)		

It is most discouraging to learn that—in spite of all our efforts in the past few years—only 13.6% of the students, about 5.5% of interns and 1% of residents plan to engage in family practice. It is quite obvious that the backbone of our present medical care delivery system, the general practitioners, are not going to be replaced when they cease practice.

Three hundred and thirty students (55%) 182 interns (72%) and 364 residents (66%) have selected their respective specialties. Thirty-one per cent of students, 22% of interns and 25% of residents chose internal medicine or one of its sub-specialties. Twenty-three per cent of students, 19% of interns and 17.5% of residents chose

some branch of surgery. Obstetrics-gynecology, psychiatry and radiology scored about equal, with each specialty being chosen by about 1% of the students, interns and residents. The remaining trainees' interests were divided in about 15 other specialties.

The next question was:

594 Students			
Do you plan to practice solo?	Yes	No	No answer
	87	331	176
	(14.6%)	(56.0%)	(29.0%)
Join a group?	375	52	169
	(60.0%)		
252 Interns			
Do you plan to practice solo?	Yes	No	No answer
	37	114	101
	(14.7%)	(45.0%)	
Join a group?	139	21	92
	(55.0%)		
550 Residents			
Do you plan to practice solo?	Yes	No	No answer
	82	310	158
	(15.0%)		
Join a group?	321	71	158
	(58.0%)		

The percentage of those who plan to practice solo is remarkably consistent throughout the training group (about 15%). Also, the percentage of those who would have decided to join a group remains fairly consistent throughout training, (55 to 60%). It is also true that roughly 25% have either not made up their minds or are

going into research, teaching, administration, or industrial medicine.

The next question was:

If you plan to do solo practice do you			
594 Students			
A. Plan to practice	Yes	No	No answer
in a city	79	68	447
B. Go to a medium-sized town	89	51	454
C. Settle in a rural area	32	74	488

If you plan to do solo practice do you			
252 Interns			
A. Plan to practice	Yes	No	No answer
in a city	40	21	191
B. Go to a medium-sized town	26	27	199
C. Settle in a rural area	6	37	210

If you plan to do solo practice do you			
550 Residents			
A. Plan to practice	Yes	No	No answer
in a city	105	40	405
B. Go to a medium-sized town	76	49	425
C. Settle in a rural area	106	75	369

In retrospect the question was not a very good one; but when the questionnaire was circulated it was believed most graduates would embrace solo practice. The primary purpose of the question was to learn what we could expect of the future distribution of physicians throughout the state. The answers to this question (considering the great number that didn't answer it at all) confirms the answers to the previous question emphasizing that most future doctors are interested in joining a group. It further suggests that many young doctors might be interested in proceeding to a medium-size town.

The last question was:

If you plan to join a group would you prefer one organized as			
594 Students			
	Yes	No	No answer
A. Medical corporation	261 (44.0%)	63 (10.0%)	270
B. Partnership	119 (20.0%)	113 (18.0%)	362
C. Foundation	58 (10.0%)	141 (23.7%)	395
D. No legal organization-sharing facilities	74 (12.0%)	141 (23.7%)	379

If you plan to join a group would you prefer one organized as			
252 Interns			
	Yes	No	No answer
A. Medical corporation	107 (42.0%)	16	129
B. Partnership	49 (19.0%)	37 (14.0%)	166

	14 (0.6%)	47 (18.0%)	191
C. Foundation			
D. No legal organization-sharing facilities	17 (0.6%)	49 (19.0%)	186

If you plan to join a group would you prefer one organized as			
550 Residents			
	Yes	No	No answer
A. Medical corporation	241 (44.0%)	42 (7.6%)	267
B. Partnership	107 (19.4%)	71 (12.8%)	372
C. Foundation	48 (6.6%)	98 (17.6%)	404
D. No legal organization-sharing facilities	45 (6.5%)	106 (19.0%)	399

It would appear that of those who plan to join a group, a greater percentage would choose a corporate structure. Many are interested in a partnership.

One purpose of the questionnaire was to try to get some idea of the effectiveness of our campaign to obtain more doctors for Illinois, particularly generalists, for the downstate areas. Of the 5,000 students, interns and residents, a significant sample (1,396 or 28%) answered the questionnaire. Although the plans of the young often change as they mature, they are significant and usually fulfilled. Therefore, I believe we may gain certain guidelines from these answers.

Although we learn that only 30% of those in training in Illinois plan to practice in the state, we do get some physicians from other training areas. Our record is roughly that we license about half as many doctors as we graduate students in our medical schools.

I believe the answers to our questionnaire make it clear that we can expect few to become general practitioners, and certainly few generalists are going into rural areas, where the need is greatest. It is encouraging, however, that many plan to go to a "medium-sized town," or even to a rural area as a specialist.

Of great significance is the anticipation they have of joining a group. This is very encouraging and supports my thought that the only way to get new, young doctors to practice outside the great cities is to establish group practice units in smaller towns. Such units would be owned and controlled by the physician members. The establishment of groups of this type is urgent, since there are plans for "closed panel" group practice units throughout the state, owned and controlled by "not-for-profit" lay organizations. ◀

NEW

PHARMACEUTICAL

SPECIALTIES

by Paul deHaen

For detailed information regarding indications, dosage, contraindications, and adverse reactions, refer to the manufacturer's package insert or brochure.

Single Chemicals: Drugs not previously known, including new salts.

Duplicate Single Products: Drugs marketed by more than one manufacturer.

Combination Products: Drugs consisting of two or more active ingredients.

New Dosage Forms: Of a previously introduced product.

The following new drugs have been marketed:

NEW SINGLE CHEMICAL

DIAPID Nasal Spray Antidiuretics R

Manufacturer: Sandoz Pharmaceuticals

Nonproprietary name: Lypressin

Indications: Control or prevention of symptoms and complications of diabetes insipidus due to deficiency of endogenous posterior pituitary antidiuretic hormone.

Contraindications: None known

Dosage: 1 or 2 sprays to one or both nostrils whenever frequency of urination increases or significant thirst develops. Usual dose is 1 or 2 sprays in each nostril q.i.d.

Supplied: Plastic squeeze bottle, 0.185 mg./cc (Equivalent to 50 U.S.P. Posterior Pituitary Units)

DUPLICATE SINGLE PRODUCTS

DEXA-SEQUELS Antiobesity preparations—

Amphetamines R

Manufacturer: Lederle

Nonproprietary name: Dextroamphetamine sulfate

Indications: Exogenous obesity, as a short term adjunct in weight reduction based on caloric restriction.

Contraindications: Advanced arteriosclerosis, symptomatic cardiovascular disease, moderate to severe hypertension, hyperthyroidism, known hypersensitivity or idiosyncrasy to the sympathomimetic amines, agitated states, patients with a history of drug abuse. During or within 14 days following administration, hypertensive crises may result.

Dosage: One capsule in the morning unless daily routine differs from normal (e.g. persons working night shift).

Supplied: Capsules, 10 and 15 mg., Sustained release

DIGOXIN Cardiotonic R

Manufacturer: Lederle

Nonproprietary name: Digoxin

Indications: Congestive heart failure, atrial fibrillation, atrial flutter, supraventricular tachycardia and premature extrasystoles. Refractory ventricular paroxysmal tachycardia.

Dosage: Adults and children over 10 years:

Rapid digitalization: 1.5 mg. initially followed by 0.25 to 0.5 mg. every 6 hrs. Average total dose, 2 to 3 mg.

Slow digitalization: 0.5 to 1.0 mg. daily for approximately one week followed by appropriate maintenance dosage for a period of 1 to 3 weeks. Usual maintenance dosage, 0.25 to 0.75 mg.

Supplied: Tablets, 0.25 mg.

ECTASULE-MINUS Nasal decongestant

JR & SR Bronchodilator R

Manufacturer: Fleming

Nonproprietary name: Ephedrine sulfate

Indications: Hay fever patients who complain of drowsiness from antihistamines.

Contraindications: Use with caution in cardiac and vascular diseases, hyperthyroidism, circulatory collapse and prostatitis.

Dosage: One capsule every 12 hrs. or in severe cases every 8 hrs.

Supplied: Capsules, 30 and 60 mg.

HAUTOSONE Dermatological preparation R

Manufacturer: Hautarts, Div. Fellows Med. Mfg. Co., Inc.

Nonproprietary name: Hydrocortisone

Indications: Various susceptible dermatoses

Contraindications: Tuberculosis, fungus and most viral lesions, including herpes simplex, varicella and vaccinia. Not intended for ophthalmic use.

Dosage: Apply to lesion and massage in, 2 to 4 times daily. One to two drops will cover 2 to 4 square inches.

Supplied: Solution 0.5%

COMBINATION PRODUCTS

EPICAR Ophthalmic solution R

Manufacturer: Barnes-Hind

Composition: Pilocarpine HC1 1%, 2%, 3%, 4%, or 6%
Epinephrine HC1 0.65%

Indications: Control of simple open-angle glaucoma

Contraindications: Narrow-angle glaucoma and sensitivity to pilocarpine and/or epinephrine.

Dosage: One or two drops in eye every 6 to 8 hrs.

Supplied: Dropper vials, 15 cc

KINESED G.I. preparation R

Manufacturer: Stuart

Composition:

Phenobarbital	16	mg.
Hyosyamine Sulfate	0.1	mg.
Atropine Sulfate	0.02	mg.
Scopolamine HBr	0.007	mg.
Simethicone	40	mg.

Indications: Symptomatic relief in a variety of gastrointestinal disorders.

Contraindications: Hypersensitivity to belladonna alkaloids or barbiturates.

Dosage: Adults: One or two tablets 3 or 4 times daily

Children 2-12 yrs.: $\frac{1}{2}$ tablet 3 or 4 times daily

Supplied: Tablets, fruit-flavored, chewable

KORYZA Cold preparation R

Manufacturer: Fellows Testagar Div. of Fellows Med. Mfg. Co., Inc.

Composition:

Phenylephrine HC1	15	mg.
Phenylpropanolamine HC1	25	mg.
Chlorpheniramine Maleate	4	mg.
Acetaminophen	300	mg.
Hyoscyamine HBr	0.134	mg.
Hyoscine HBr	0.008	mg.
Atropine Sulfate	0.020	mg.

Indications: Temporary relief of respiratory symptoms.

Contraindications: Glaucoma, asthma, hepatitis, pregnancy toxemias, pyloric obstruction, prostatic hypertrophy and intolerance to any of the classes of drugs included.

Dosage: One tablet every 3 or 4 hrs.
Supplied: Tablets

NICOL Tablets Cold preparation R

Manufacturer: Warner-Chilcott

Composition: Phenylpropanolamine HCl 50 mg.
Chlorpheniramine maleate 4 mg.
Glyceryl guaiaacolate 200 mg.
Dextromethorphan HBr 30 mg.

Indications: Temporary relief of respiratory symptoms.

Contraindications: Hypersensitivity to any ingredient

Dosage: Adults: One tablet 3 or 4 times a day.
Children 6-12: One-half tablet 3 or 4 times a day

Supplied: Tablets

PRAMET FA Vitamins-Prenatal o-t-c

Manufacturer: Ross

Composition: Iron (as Ferrous Sulfate) 60 mg.
Folic Acid 1 mg.
Vitamin A Acetate (4000 Units) 1.2 mg.
Vitamin D₂ (400 Units Ergocalciferol) 10 mcg.
Vitamin C (Ascorbic Acid) 100 mg.
Vitamin B₁ (Thiamine Mononitrate) 3 mg.
Vitamin B₂ (Riboflavin) 2 mg.
Vitamin B₆ (Pyridoxine HCl) 5 mg.
Vitamin B₁₂ (Cyanocobalamin) 3 mcg.
Niacinamide (as Niacinamide HCl) 10 mg.
d-Calcium Pantothenate 1 mg.
Iodine (as Calcium Iodate) 0.1 mg.
Calcium (as Calcium Carbonate) 250 mg.
Copper (as Cupric Chloride) 0.15 mg.

Indications: Nutritional supplementation during pregnancy

Contraindications: None mentioned

Dosage: One tablet daily or as directed by physician

Supplied: Tablets

NEW DOSAGE FORM

ALPEN Penicillin & Deriv.

R

Manufacturer: Lederle

Nonproprietary name: Ampicillin trihydrate

Indications: Treatment of infections due to susceptible strains of gram-negative and gram-positive organisms.

Contraindications: History of allergic reaction to any of the penicillins

Dosage: Adults: 250-500 mg. every 6-8 hrs.

Children: 50-100 mg./kg./day in divided doses every 6-8 hrs.

Supplied: Oral suspension, 125 and 250 mg./5 cc.

COLY-MYCIN M Parenteral Antibiotics—

B & M Spectrum

R

Manufacturer: Warner-Chilcott

Nonproprietary name: Colistimethate sodium

Indications: Acute or chronic infections due to sensitive strains of gram-negative bacilli.

Contraindications: Patients with history of sensitivity to the drug. Safety during pregnancy has not been established. Daily dose should be reduced in the presence of renal impairment.

Dosage: i.v. or i.m., 2 to 4 divided doses of 2.5 to 5 mg./kg. per day.

Supplied: Vials, 20 or 150 mg. colistin base activity per vial as a lyophilized cake.

NICOL Elixir Cold preparation

R

Manufacturer: Warner-Chilcott

Composition: Each 15 cc contains:

Phenylpropanolamine HCl 25 mg.
Chlorpheniramine maleate 2 mg.
Glyceryl guaiaacolate 100 mg.
Dextromethorphan HBr 15 mg.
Alcohol 10%

Indications: Temporary relief of respiratory symptoms

Contraindications: Hypersensitivity to any ingredient

Dosage: Adults: Two tbs. 3 or 4 times daily

Children 6-12: One tbs. 3 or 4 times daily

4-6: Two tsp. 3 or 4 times daily

2-4: One tsp. 3 or 4 times daily

Supplied: Elixir

New voluntary product standard for clinical thermometers approved

A new Voluntary Product Standard, PS 39-70, "Clinical Thermometers (Maximum-Self-Registering, Mercury-In-Glass)" has been approved for publication by the National Bureau of Standards, U. S. Department of Commerce, with an effective date of October 15, 1970. The standard was processed as a revision of Commercial Standard CS 1-52 in accordance with the "Procedures for the Development of Voluntary Product Standards" published by the U. S. Department of Commerce.

The purpose of this standard is to establish nationally recognized classifications and performance requirements for thermometers which are used to measure body temperatures, including temperatures to be used

for determining date of ovulation and basal metabolic rate. Included are requirements for bulb and stem glasses, temperature scale graduations, accuracy, ease of resetting, and retention of temperature indications.

Printed copies of the standard will be available from the U. S. Government Printing Office, Washington, D.C. 20402 in three or four months. In the meantime, the recommended standard, designated TS 151c, "Clinical Thermometers (Maximum-Self-Registering, Mercury-In-Glass)," may be used. Copies of TS 151c are available without charge from the Office of Engineering Standards Services, National Bureau of Standards, Washington, D.C. 20234.

Clinics for Crippled Children Scheduled

Twenty-three clinics for Illinois' physically handicapped children have been scheduled for January by the University of Illinois, Division of Services for Crippled Children. The Division will hold nineteen general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing service. There will be three special clinics for children with cardiac conditions and rheumatic fever, and one for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- Jan. 6—Hinsdale—Hinsdale Sanitarium
- Jan. 7—Sterling—Community General Hospital
- Jan. 7—Flora—Clay County Hospital
- Jan. 7—Cairo—Public Health Department
- Jan. 8—Chicago Heights Cardiac — St. James Hospital
- Jan. 12—East St. Louis—Christian Welfare Hospital
- Jan. 12—Peoria General—St. Francis Children's Hospital
- Jan. 13—Champaign-Urbana — McKinley Hospital
- Jan. 13—Elgin—Sherman Hospital
- Jan. 13—Joliet—St. Joseph's Hospital
- Jan. 14—Springfield General — St. John's Hospital
- Jan. 14—Macomb — McDonough District Hospital
- Jan. 14—Decatur—Decatur Memorial Hospital

- Jan. 19—Quincy—Blessing Hospital
- Jan. 19—Rock Island General—Moline Public Hospital
- Jan. 20—Evergreen Park—Little Company of Mary Hospital
- Jan. 21—Rockford — Rockford Memorial Hospital
- Jan. 21—Elmhurst Cardiac—Memorial Hospital of DuPage County
- Jan. 22—Chicago Heights Cardiac — St. James Hospital
- Jan. 26—Peoria General—St. Francis Children's Hospital
- Jan. 27—Springfield Pediatric Neurology—Diocesan Center
- Jan. 27—Mt. Vernon—Good Samaritan Hospital
- Jan. 27—Centralia—St. Mary's Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

SOS offers a new "kick the cigarette habit" approach

SOS is the rescue ship for the distress call of those smokers who need a proven method to kick the cigarette habit. The SNUFFED OUT SYSTEM (SOS) heralds a brand new approach to the problem of how to quit smoking.

Using the tools contained in the recently published book, SNUFFED OUT, the results are positive and successful. SOS'ers testify to the success of the approach.

The book, SNUFFED OUT, is rapidly becoming the daily companion of SOS'ers and the key that opened the lock to stop smoking forever. Cost is \$1.00 plus 35¢ for postage and handling to: SNUFFED OUT, Box 236MM South Elgin, Illinois 60177.

Looking for a Place to Practice? Placement Service Lists Openings

In an effort to reduce the number of towns in Illinois needing practicing physicians, the *Journal* is publishing synopses submitted to the Physicians Placement Service concerning openings for doctors.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the placement service.

Information and comments are also requested from physicians living near the communities listed as to the real need and the ability of the town to support additional physicians.

Inquiries and comments should be directed to Mrs. Robert Swanson, Secretary, Physicians Placement Service, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601.

Subsequent to the listings over the past 30 months, the following supplemental list of openings is furnished. This will be continued next month.

HENRY COUNTY: Kewanee; population: 18,000. Trade area: 35,000. New medical center across from 150 bed Community Hospital. Suite of 1000 sq. ft. available for immediate occupancy. Reasonable rent. Solo practice. Ten physicians in community. Agriculture and industry. Catholic and Protestant churches. Six grade schools; two high schools. Local junior college. Country club. Two golf courses. For further information contact: William Neilson, M.D., 716 Elliott Street, Kewanee. Phone: 2263.

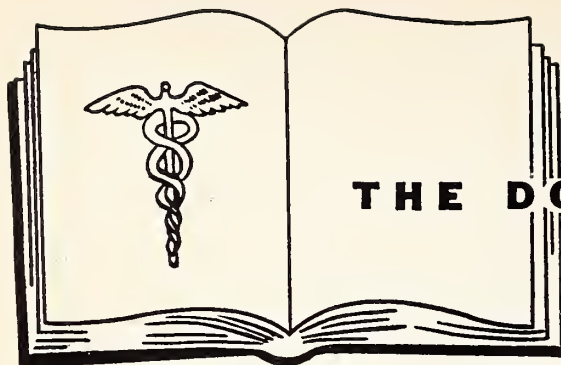
MADISON COUNTY: Collinsville; population: 21,000. Position available immediately. Young man willing to take over practice and go into partnership with long range plan of completely assuming practice. Minimum starting salary: \$2,000 monthly. No investment necessary. Opportunity for partnership after one year. Complete physiotherapy, EKG, BMR and lab. Eleven GPs in community. Four nearby hospitals. For further information contact: Morris Rothenberg, M.D., 217 W. Clay St., Collinsville. Phone: 344-0090.

MARSHALL COUNTY: Lacon; population: 2300. Opening for GP or surgeon. Lacon Clinic—two physicians. Full partnership after three years. Use three Peoria hospitals; 2000 beds. Agriculture and J&L Steel Co. Protestant and Catholic churches. Public schools. Country club with golf course and pool. For further information contact: Merle Swearingen, M.D., 202 S. Main, Lacon 61450.

McHENRY COUNTY: Crystal Lake; population: 14,000. Trade area: 63,000. Ten practicing physicians. Nearest hospital at McHenry, eight miles. Five drug stores. New and older offices available; new clinic also available. Sixteen churches; seven grade schools, one high school. Local and international organizations. Three golf courses; lake; exceptional parks. Population nearly doubled in last 10 years. For further information contact: John Boehner, Chamber of Commerce, Box 256, Crystal Lake.

RANDOLPH COUNTY: Tilden; population: 1000. Trade area: 16,000. Nearest physicians, six miles. Town without a physician for many years. Fifty miles from St. Louis. New office being provided by citizens. Home rent free for one year; office for two years. Predominant nationalities: German and Irish. Agriculture, industry and coal mining. Three churches. Grade and high schools. Golf course. For further information contact: Lawrence Campbell, Box 201, Tilden. Phone: 618-587-2061.

SANGAMON COUNTY: Illiopolis; population: 1,200. Located halfway between Springfield and Decatur. Only physician died recently. Two factories. Population of nearby Decatur, 100,000. Previous physician's office available if desired. Agriculture and industry. Four Protestant and Catholic churches. Grade and high schools. College in Decatur. Four country clubs. Four hospitals available. For further information contact: Mr. R. E. McDermott, 345 Fifth St., Illiopolis. Phone: 217-486-2721.



THE DOCTOR'S LIBRARY

EMERGENCY ROOM JOURNAL ARTICLES. Edited by Abraham Gelperin, M.D., Dr.P.H., M.S.H.A., and Eve Arlin Gelperin, R.N., B.S. Medical Examination Publishing Co., Inc. Flushing, New York. 248 pages. \$8.00.

This volume is a compilation of 50 of the most recent pertinent journal articles related to the theory and practice of running an emergency room. It will prove extremely useful to all physicians, nurses and administrators involved in the organization of this department.

OUTPATIENT SERVICES JOURNAL ARTICLES. Edited by Vivian Vreeland Clark, R.N., Ed.D. Medical Examination Publishing Co., Inc., Flushing, New York. 318 pages. \$8.00.

This volume is a compilation of 50 of the most recent pertinent journal articles related to outpatient services. It is an up-to-date review of the current thinking in this field, in one concise, easy-to-read manual, thereby eliminating time-consuming research for new ideas and innovations.

Articles have been grouped as follows: 1) The Ambulatory Clinic Patient & His Needs; 2) Problems, Issues & Observations on the Delivery of Ambulatory Health Services; 3) Patterns & Examples of Ambulatory Clinic Services; 4) Multiphasic Screening; 5) Health Services Personnel in Ambulatory Clinics.

AFTER VAGOTOMY. Edited by J. Alexander Williams and Alan G. Cox. Appleton-Century-Crofts. New York, 1969.

This book is an attempt to assess the effect of vagotomy which has been used in the treatment of peptic ulceration for just over twenty-five years. The authors of the volume are authorities in the field and combine British investigators with authorities

from the United States. An eloquent foreword is provided by Dr. Francis D. Moore of Harvard, and contributors from the United States include Drs. Walter Ballinger, Irving Enquist, Ward Griffen and William Silen.

The book is divided into six sections which deal with the pathophysiology of vagotomy, results of vagotomy, complications of vagotomy, practical problems, special indications, and vagotomy and after.

The volume is a careful compendium of the effects of vagal nerve section and includes a careful assessment of unresolved problems. Appropriate tables and illustrations are included to document the material in the text. Perhaps, one of the most important contributions that the authors make in the book is to indicate areas in which understanding of the effects of the vagal nerve and vagal nerve sections remains uncertain. Each chapter has an appropriate set of references.

The book should be useful to students of gastrointestinal physiology and to clinicians interested in the treatment of peptic ulceration.

John M. Beal, M.D.

ILLUSTRATED LABORATORY TECHNIQUES. Edited by Nozomu Kosakai, M.D. Medical Examination Publishing Co., Inc., Flushing, New York. 230 pages, 308 illustrations (23 colored). \$10.00.

Recent advances in laboratory techniques have resulted in increasing numbers of laboratory tests being performed in doctors' offices. This book is a simple guide to enable office personnel to perform routine laboratory procedures with little supervision. It is a valuable asset for the doctor's office, as well as medical laboratories.



The Fifth Horseman—Drug addiction

One of the most frightening problems of this decade is the continued spread of narcotic addiction in the United States. The emphasis on the dangers of taking drugs as a method of dissuading teenagers from their use has been judged a failure by the National Institute of Mental Health. Lectures from authorities such as the police, physicians, ex-narcotic addicts and others have not proved to be effective. One key to the problem is the teenager in junior high school or freshman entering high school who opposes drugs. A personal survey of over 100 thirteen and fourteen-year-olds in my community showed the majority to be actively opposed to taking drugs. The most common answers were that taking drugs was "dumb" or "stupid." After four years of unremitting pressure from the organized drug using forces within the high schools, the percentage of college freshmen who state that taking drugs is dumb or stupid is distressingly small.

One way to combat drug addiction is to have teenagers who oppose the use of drugs form anti-drug study groups in every high school. Teachers and principals generally

have not utilized this approach in combating the menace of drug addiction. The establishment of anti-drug study groups will require the advice and encouragement of school authorities, but in order to be effective, the students themselves who are opposed to taking drugs must be free to control and administer them. The anti-drug study group must be free to invite outside authorities to educate and inform the group. The group would invite and attempt to win the minds of the uncommitted teenagers to the anti-drug group. The important thing is the anti-drug study group will provide a counter peer group as a rallying point for teenagers who oppose taking drugs.

In this way a mental vaccine against the spread of narcotic addiction can be given to large numbers of teenagers to develop resistance against the drug users.

Narcotic addiction is the apocalyptic fifth horseman who is abroad in the land. We must stand and oppose this menace with every resource at our command.

Harvey Kravitz, M.D.

When What Goes Down Comes Up

They say what goes up must come down. But the government can make what goes down come up—when it "seasonally adjusts" unemployment figures. Last May, unemployment DROPPED 170,000. But because it did not drop as much as it normally does from April to May, BLS reported—and all the scare headlines proclaimed—that it ROSE from 4.8 to 5%!

Hearing conservation endorsed by ISMS

The problems associated with noise are receiving increased attention by the public, industry, workers, state and federal agencies. As physicians, we are concerned with the general effects of noise and particularly as it affects the sense of hearing.

The Chicago Laryngological and Otolaryngological Society is familiar with the studies, recommendations and guidelines made by the Committee on Conservation of Hearing of the American Academy of Ophthalmology and Otolaryngology for conservation of hearing in noise. For the past 25 years, the Committee on Conservation of Hearing has been investigating and studying the many problems arising from noise-exposure. This Committee has published the *Guide for Conservation of Hearing in Noise*,¹ which offers a practical program for the evaluation of noise-exposure, means of noise reduction, the use of personal ear protection and how to conduct hearing testing in industry. This guide has been prepared by knowledgeable professional personnel, based upon their experiences in the field of otology and the industrial environment. Guidelines and regulations for permissible noise-exposure in industry have recently been established by the U.S. Department of Labor.²

Hearing loss resulting from noise-exposure is a scheduled compensable occupational disease in the majority of states and Canadian Provinces.³ It, therefore, becomes necessary for the physician, usually the otolaryngologist, to evaluate causal relationship, the extent and degree of the hearing loss and the percentage of hearing

impairment. The American Medical Association has published the *Guide for the Evaluation of Permanent Impairment of the Ear, Nose and Throat and Related Structures*,⁴ based upon the recommendations of the Committee on Conservation of Hearing. Workmen's Compensation and medical-legal cases for noise exposure, are also associated with social, political and economic problems which do not call for medical decisions or recommendations. Such matters as to whether or not compensation is paid for loss of hearing, how much compensation and under what conditions are decisions to be made by the courts, communities and legislative bodies are considered.

Attention is also directed to medical responsibility in Hearing Conservation Programs as described in the *Guide*¹: "*The conservation of any human function is primarily a medical responsibility. Hearing conservation is no exception. Prevention, diagnosis and treatment of hearing loss, validation and approval of audiometric records; and the final assessment of measurement of hearing are medical responsibilities. Any hearing conservation program without medical supervision must be considered inadequate.*"

The Chicago Laryngological and Otolaryngological Society through its Committee on Industrial Health endorses the above principles and guidelines. It advocates their use in dealing with the problems arising from noise-exposure.

In addition, the Ear, Nose and Throat Committee of the Illinois State Medical Society also endorses this position and will submit it to the Board of Trustees at the next meeting in January, 1971, for its approval.

References

1. Committee on Conservation of Hearing, "Guide for Conservation of Hearing in Noise," *Transactions*, American Academy of Ophthalmology and Otolaryngology, Revised 1969.
2. Department of Labor, "Safety and Health Standards," *Federal Register*, May 20, 1969, Vol. 34, No. 96, page 7948.
3. Fox, Meyer S., M.D., "Comparative Provisions for Occupational Hearing Loss," *Arch. Otolaryng.* March 1965. Vol. 81, pp. 257-260, Updated 1969—(*National Safety News*, Feb., 1970).
4. Committee on Medical Rating of Physical Impairment: "Guide to the Evaluation of Permanent Impairment: Ear, Nose, Throat and Related Structures," *JAMA*, Aug. 19, 1961, 177: 489-501.

AMA Delegation

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Elected May 21, 1968

(to serve from Jan. 1, 1969 to Dec. 31, 1970)

MAURICE M. HOELTGEN

1836 West 87th Street, Chicago 60620

LEO P. A. SWEENEY

10400 S. Western Avenue, Chicago 60643

H. CLOSE HESSELTINE

5807 South Dorchester, Chicago 60637

WILLIAM K. FORD

303 North Main Street, Rockford 61101

JACOB E. REISCH

1129 South 2nd Street, Springfield 62704

Elected May 21, 1969

(to serve from Jan. 1, 1970 to Dec. 31, 1971)

EDWARD A. PISZCZEK

6410 North Leona, Chicago 60646

HAROLD A. SOFIELD

715 Lake Street, Oak Park 60301

PHILIP G. THOMSEN

13826 Lincoln, Dolton 60419

THEODORE GREVAS

1800 Third Avenue, Rock Island 61201

HARLAN ENGLISH

909 North Logan Avenue, Danville 61833

EDWARD W. CANNADY

4601 State Street, East St. Louis 62205

Elected May 20, 1970

(to serve from Jan. 1, 1971 to Dec. 31, 1972)

Maurice M. Hoeltgen

Francis W. Young

H. Close Hesseltine

Carl E. Clark

Joseph R. Mallory

ALTERNATE DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Elected May 21, 1968

(to serve from Jan. 1, 1969 to Dec. 31, 1970)

THEODORE R. VAN DELLEN

1000 Lake Shore Plaza, Chicago 60611

ALLISON L. BURDICK, SR.

5906 West North Avenue, Chicago 60639

ARKELL M. VAUGHN

9012 S. Leavitt Street, Chicago 60620

PAUL A. DAILEY

620 N. Main St., Carrollton 62016

JACK GIBBS

Coleman Clinic, Canton 61520

Elected May 21, 1969

(to serve from Jan. 1, 1970 to Dec. 31, 1971)

HERSCHEL BROWNS

4600 North Ravenswood Ave., Chicago 60640

GEORGE C. TURNER

6627 Ponchartrain Avenue, Chicago 60646

FRANCIS W. YOUNG

9933 S. Western Avenue, Chicago

MORGAN M. MEYER

573 South Lombard, Lombard 60148

CARL E. CLARK

225 Edward Street, Sycamore 60178

JOSEPH R. MALLORY

Linck Clinic, Mattoon 61938

Elected May 20, 1970

(to serve from Jan. 1, 1971 to Dec. 31, 1971)

Theodore R. VanDellen

Fred A. Tworoger

Frank J. Jirka, Jr.

Joseph R. O'Donnell

Jack Gibbs

To fill unexpired terms starting January 1, 1971.

William M. Lees, replacing Francis W. Young
as alternate

Boyd McCracken replacing Carl E. Clark as
alternate

Glen E. Tomlinson replacing Joseph R. Mallory
as alternate

Honorary Delegates

Edwin S. Hamilton, 151 N. Schuyler Street,
Kankakee 60901

George F. Lull, 2440 Lakeview Ave., Chicago
60614

Burtis E. Montgomery, 37 South Main Street,
Harrisburg 62946

Walter C. Bornemeier, 4665 Peterson Avenue,
Chicago 60646

Delegate—AMA Section

Henry A. Holle, 1350 N. Lake Shore Drive,
Chicago 60610

opposing any repeal of the anti-substitution provision in Illinois. The Board accepted, for information, a report of the ISMS Committee on Drugs and Therapeutics which took a more favorable viewpoint on this subject. The Pharmacy Board action applies only to licensure and makes no alteration in ongoing pharmacy practices. The effect of the ISMS action is to call for no change in the relationship between physicians and pharmacists in the matter of drug substitution.

Student Activity

Endorsement was given to the continuation of the Medical Education Community Orientation (MECO) program for 1971 as conducted by the Student American Medical Association (SAMA). This program, originally developed in Illinois, has been expanded to twenty-three states. One hundred and forty-one students were involved in fifty-four hospitals in Illinois during 1970. An Evaluation Conference, to be held in Chicago, January 1971, was approved in principle. The Board recommended to the Finance Committee, inclusion of \$1,000 in the SAMA Advisory Committee budget for 1971 to assist with the Conference and suggested that the SAMA Committee seek additional sources of revenue. The Conference will bring together the program participants, representatives of the hospitals involved and others. Staff support for the MECO project and the Evaluation Conference will be provided.

In related action, the Board requested the Illinois delegates to AMA to introduce a resolution at the forthcoming Clinical Session in Boston directing the AMA Council on Medical Education to study the MECO project and consider recommendations to medical schools for granting elective credit for participation in this program.

A recommendation that students assigned to ISMS Councils meet quarterly to aid in disseminating information about Society activities to students as a whole was approved. Space will be made available in the Illinois Medical Journal for this purpose.

Specialty Representation on ISMS Councils

Procedure has been established enabling specialty societies to be directly represented on ISMS Councils. Representatives nominated by the specialty society, after approval by the ISMS Board of Trustees, are designated consultant members of the Council to which appointed (without vote). The first application of this procedure has resulted in the appointment of Dr. S. Dale Loomis as consultant to the Council on Mental Health and Addiction, representing the interests of the Illinois Psychiatric Society.

Staff Reorganization

The forthcoming retirement of a senior staff member, Mrs. Frances Zimmer, and a desire to make further maximum use of existing staff capabilities has resulted in a reorganization plan for the ISMS staff. Acting on recommendations of the Executive Committee, the Board adopted the plan suggested by the Executive Administrator. Under the plan, Mr. James Slawny will be promoted to Assistant Executive Administrator with responsibility for coordinating the Society's various ongoing programs. In addition to Administration, staff divisions will be

maintained as follows: Publications and Scientific Services, Richard Ott, Director; Legislation and Public Affairs, Timothy Selleck, Director; Economics, Joseph Lotharius, Director; Public Relations, Bob Westerbeck, Director. Mr. Perry Smithers and his staff will be transferred to the Administrative Division with Mr. Smithers named Assistant to the Executive Administrator. He will retain his duties as Convention Manager, assume those formerly handled by Mrs. Zimmer, with additional duties to be assigned.

Group Immunization and Examination of School Children

An error in reporting actions of the 1970 House of Delegates as published in the Abstracts of the House, May 1970 was noted. The abstracts contained a notation that policy was adopted which requires that

"the ISMS urge all school districts in the state to provide funds in the budget to employ sufficient doctors and other health professionals to carry out school health procedures as required by law."

Examination of the official transcript of proceedings of the House of Delegates reveals that this portion of the report of the Committee on Child Health was not adopted and was referred back to the Board of Trustees for assignment to the appropriate Council for further study. The Board acted to refer this matter to the Council on Environmental and Community Health. The existing policy on this matter as contained in the Policy Manual reads as follows:

"All physical examinations should be performed in the physician's office. No examinations should be conducted on a group basis unless authorization has been given by the local county medical society in a single instance or for a specific purpose.

This general statement does not apply to the industrial or occupational health physician in his in-patient activities."

PRO vs. PSRO

Attention was given to the several proposals now under consideration by the Congress in the field of peer review. Action on these programs is anticipated in conjunction with the Social Security Amendments as contained in HR 17550 which has passed the House of Representatives and is now before the Senate Finance Committee. Section 227 of the Act, as passed by the House, would permit the Secretary of HEW to convene panels composed of physicians and non-physicians to examine utilization charges, etc. under the Medicare and Medicaid programs. To offset this development, the AMA has developed a plan for the formation of a peer review organization (PRO) which would authorize this activity under the control of state and county medical societies utilizing physicians only for the review decisions. The Senate Finance Committee is currently considering an amendment to HR 17550 submitted by Sen. Wallace Bennett (R-Utah), which would provide for the establishment of a Professional Service Review Organization (PSRO) which goes substantially beyond the plan recommended by AMA and would not assure complete physician control. Final action on HR 17550 and the Bennett Amendment has been postponed until the Congress reconvenes on November 16. Senate action on this bill will be subject to further consideration by a Conference Committee between the House and Senate where the

difference in actions by the two Houses will be reconciled.

In acting upon this matter, the Board endorsed PRO as defined in the AMA Medicredit bill. The Board took further action to disapprove any extension of peer review as proposed in the Bennett Amendment which differs from the AMA position at the present time.

Legal Decisions

In reversing a decision of the Lower Court in the case of Cunningham vs. MacNeal Memorial Hospital, the Illinois Supreme Court has classified blood transfusion as a product not a service. This invokes the doctrine of implied warranty and makes the physician, hospital and others libel for hepatitis contracted through blood transfusion. Legal counsel, Frank Pfeifer, advised the Board that a consent form has been developed as a temporary measure but that legislative action to grant immunity is the only permanent solution. A discussion of this issue and a copy of the suggested consent form appear in the November Illinois Medical Journal. Legislation is being drafted for introduction in the next General Assembly which convenes in January. Governor Ogilvie has offered his support for this legislation.

Legal counsel also discussed the case of Lipsey vs. Michael Reese Hospital in which the Supreme Court action effectively eliminates the two-year statute of limitation on liability actions. Modifications in the application of the discovery rule would allow action to commence within two years after date of discovery rather than two years after the incident. This case was discussed in the September issue of the Illinois Medical Journal.

Legal counsel further discussed the so-called "sick doctor" statute which provides for revocation of license for a physician who is an alcoholic, drug addict or mentally incompetent. The Board acted to refer this matter to the Council on Legislation and Public Affairs for further study in consultation with the Committee on Licensure.

Loan Program for Inner City Students

Based upon a mandate from the House of Delegates (Resolution 70M-44) and recommendation of the Task Force on Physician Shortage and Services to Medically Deprived Areas, the Board approved meetings with representatives of the city of Chicago, the Joint Negro Appeal, Sears Foundation, the Woodlawn Organization and the Combined Community Organization. The meeting would explore the potential for establishing a loan program for medical students from the inner city, who upon completion of training would return to practice in ghetto areas. Methods of funding such a program would also be discussed.

Liaison with Interns and Residents

Acting on recommendation of the Task Force on Physician Shortage and Services to Medically Deprived Areas, the Board approved financial and staff assistance to help residents and interns located in Illinois to form a statewide organization. This will enhance membership possibilities, co-sponsorship of mutually beneficial programs and otherwise provide a means of communication with this group.

State Bureau of Toxicology

Several concerns were manifest in the report of the Council on Legislation regarding toxicology services. The State Bureau of Toxicology is being pressed into greater service with limited staff. A laboratory authorized for Springfield has never been established. In addition there is a proposal to move the Bureau from Public Health to Law Enforcement. The Board endorsed the concept of working with Dr. Yoder, Director of Public Health, to alleviate the problem and to request the Governor to retain the Bureau under the Department of Public Health. A letter to Dr. Yoder regarding the elimination of one chemist in the laboratory was also authorized.

Chiropractic Concerns—The Kentucky Plan

Recent activity by chiropractors in petitioning for coverage under Medicaid was cited. The Board adopted a recommendation to approve in principle the so-called "Kentucky Bill" which would amend the Medical Practice Act to require chiropractors (as well as all professionals under the Act) to be graduates of schools accredited by the Office of Education, U. S. Department of Health Education and Welfare as well as the National Commission on Accrediting. Further plans on this proposal will be worked out by the Council on Legislation and Public Affairs.

DVR Services

The Advisory Committee to DVR has expressed concern over the eligibility standards applied under the Division of Vocational Rehabilitation program. The Board approved a request by the Committee for the development of a questionnaire to be distributed to all county medical societies giving opportunity to each for expression of opinion regarding DVR programs in Illinois.

Physicians-On-Call

The operation of a firm called "Physicians-on-Call," which contracts to provide medical coverage for hospital emergency rooms and locum tenens for physicians was discussed. An in-depth study of this type of service by the Council on Social and Medical Services was authorized.

Licensure

The Committee on Licensure reported progress in its study of licensing problems, particularly reciprocity licensing for physicians. An early meeting with the physician members of the Medical Examining Committee of the Department of Registration and Education is scheduled. In acting on the report, the Board endorsed a recommendation to be forwarded to the Medical Examining Committee as follows:

that if a physician is licensed in another state; or, has passed a national board examination; or, is certified in his specialty; or, is recognized as board eligible; there should be a realistic appraisal in granting licensure by reciprocity or endorsement after appropriate investigation.

In related action, the Board agreed with the Council on Education and Manpower that Legislation should be developed to amend the time requirements in the Medical Practice Act to accommodate students admitted to medical school with advance standing.

Annual Meeting

Preliminary plans for the 1971 Annual Meeting were reviewed. Great enthusiasm was expressed relative to the facilities at Arlington Towers. Self-testing and short courses will be new features at the meeting. The general format will be as follows:

8:30-10:00 a.m.—Instructional courses (12 each day)

10:00-10:30 a.m.—Exhibit break

10:30-12:00 noon—Specialty society programs

2:00- 4:00 p.m.—General sessions

In other actions, the Board—

- Requested the Committee on Health Care Financing to explore with Department of Mental Health Director, Dr. Albert Glass, procedures for resolving problems occurring in the Department's purchase of psychiatric services from physicians.

- Authorized reprinting and updating of the Society's brochure describing membership services and distribution of a newly-developed new member packet.

- Authorized the mailing of materials to all physicians in support of the Water Pollution Bond issue.

- Authorized the Executive Administrator to work with Dr. Albert Snoke, Governor's Coordinator for Health, in the latter's efforts to bring various agencies together for a discussion of problems in health care.

- In connection with the above, authorized the Executive Administrator to develop a listing of objectives for later consideration by the Executive Committee and Board of Trustees.

- Awarded the printing contract for the Journal to Neely Printing, and the contract for "Pulse" to Carl Gorr Printing.

- Approved development of a readership survey of the Illinois Medical Journal.

- Approved the initiation of legislation to require physical exams for non-public school bus drivers and greater enforcement of this requirement for public school bus drivers.

- Granted permission for the Council on Economics and Peer Review to publicize peer review information in the IMJ.

- Approved, in principle, establishment of a statewide Council for Home Health Services.

- Authorized a one-day workshop in 1971 to cover "Improving Physician-Nurse Communications," to be held in cooperation with the League for Nursing and the Illinois Nurses Association.

- Referred to the Finance Committee a request for funds to support student attendance at 1971 AMA meetings and approved attendance of four students at the Boston clinical meeting under present budget allocations.

- Approved in principle legislation to create a "Critical Health Problems and Comprehensive Health Education Program" in the Department of Public Instruction and referred to the Legislative Council for further consideration.

- Acted to recommend to the Illinois Department of Children and Family Services, development of a pilot program to experiment with less frequent examinations required for children—currently every two years.

- Acted to recommend to Departments of Public Instruction and Public Health that examinations required of children entering school the first time, and at fifth and ninth grades be considered valid if performed six months prior to entry or at any time during the year following such entry.

- Authorized the Public Relations Division to develop a program to educate and influence eighth and ninth graders regarding hazards of drug abuse.

- Approved a recommendation of the Child Health Committee calling for around-the-clock availability of juvenile justices in all parts of the state to declare children wards of the state whose parents are unwilling or unable to give consent for necessary medical or surgical procedures (current procedure in Cook County).

- Endorsed a suggestion from the Maternal Welfare Committee that an educational program based on maternal death studies be considered for presentation at the Annual Meeting.

Appointments and Authorizations

Recommended to the Governor, for appointment on the Illinois Delegation to the 1971 White House Conference on Aging, were: Dr. Thomas Tourlentes, Galesburg; Dr. Bertram Moss, Chicago; Dr. L. T. Fruin, Normal; and support was given to the nomination of Mrs. Ruth Scrivner, who was suggested through other channels.

The following ISMS members were recommended for appointment to the Governor's Committee for Senior Citizens: Dr. Thomas Tourlentes, Galesburg; Dr. W. W. Bowers, Granite City; Dr. J. R. Durham, Mendota; Dr. Bertram Moss, Chicago; Dr. Clyde Rulison, Roberts; Dr. LeRoy P. Levitt, Chicago; Dr. Jack Weinberg, Chicago; Dr. Edward W. Cannady, East St. Louis.

Dr. Eugene Johnson, Casey, appointed to replace Dr. James Hartney (at his request) as a member of the Board of Directors of the Health Careers Council of Illinois.

Dr. Andrew Brislen, Chicago, appointed as ISMS representative to the Illinois Council on Voluntary Health Agencies, replacing Dr. Charles Vil, Evergreen Park.

Surgical Grand Rounds

(Continued from page 593)

Dr. Conn: What about phlebitis?

Dr. Sherman: We use a polyvinylchloride catheter. We have not seen phlebitis although we have had clots in some of the catheters. We had one patient who developed a minimal amount of pulmonary hypertension, and we thought this might be due to the fact that small microemboli were being thrown from the catheter into the lungs producing pulmonary hypertension.

Dr. Conn: Then it appears that some of the phlebitis that we have seen after intravenous therapy and have been blaming on various things is probably due to contamination and bacteria.

Dr. Sherman: Let me just say that the catheter does pass through the external jugular vein. To minimize the chances of contamination we change the dressing every three days. We defat the skin with ether and then paint the skin with iodine solution and apply a small amount of Neosporin ointment. Some of our patients have

had the same catheter for two months without evidence of phlebitis.

Dr. Conn: This would speak then for a little more care in placing intravenoses and a little more attention to taking care of them.

Dr. Gabriel Lorenzo: Do you have a problem with diuresis and how do you avoid that?

Dr. Sherman: The solution we use has an osmolarity of over 1400 milliosmoles per liter. This high osmolarity results from the high concentration of glucose in the solution. Years ago, Dr. Francis Moore suggested that an insulin "chaser" be given after infusing concentrated glucose solutions. Dr. Stanley Dudrick, the originator of parenteral hyperalimentation, noted that if the glucose infusion is limited to 1.2 gm. per kilogram of weight per hour, the glycosuria is limited. We see an osmotic diuresis for about two days with glycosuria and hyperglycemia. After two to three days, the urine is negative for sugar and the blood sugar averages between 70 and 90 mgm.%. ◀

Hyperkineticism in children

About four out of every 100 grade-school children in the U.S. are hyperkinetic—the victims of excessive and uncontrolled motion.

Hyperkinesis may prevent a child from keeping up with his studies, and many children referred to mental health clinics are hyperkinetic.

Controlled dosage with Ritalin (methylphenidate hydrochloride), a central nervous system stimulant, has proved the best of several drugs prescribed for such children, Dr. J. Gordon Millichap, a Northwestern University neurologist, reports.

The hyperkinetic child is restless, impulsive, and garrulous and has a short attention span, said Dr. Millichap, professor of neurology and pediatrics and director of neurology at The Children's Memorial Hospital, Chicago.

The child's actions are irrelevant and without clear direction, focus, or object, but intelligence, achievement, and other special tests are necessary to identify hyperkinesis as the principal cause of the child's learning disorder, writes Dr. Millichap.

"The hyperkinetic child may be mentally retarded, but he is often of average or above-average intelligence but below normal in schoolwork performance."

Dr. Millichap has studied the use of drugs in treating hyperactive children for the past five years. His research has been supported by grants from the National Institute of Neurological Diseases and Blindness, the Brain Research Foundation, the W. Clement and Jessie V. Stone Foundation, and the Dreyfus Medical Foundation.

Here is what he found:

—Reporting on his own experience at The Children's Memorial Hospital, Dr. Millichap said that the best results were obtained with Ritalin. A review of medical literature, including his own reports, shows that of 337 patients who received Ritalin (methylphenidate), 84% were benefitted.

—of 415 patients treated with amphetamine (Dexedrine), another stimulant, 69% showed improvement in behavior. The stimulant deanol acetamidobenzoate (Dea-

ner) was less effective, producing improved behavior in 47% of a total of 239 patients treated by various investigators, and failing to produce any beneficial effects at all in three controlled studies.

—Chlordiazepoxide (Librium) and chlorpromazine (Thorazine) controlled hyperkinetic behavior in 60% of the cases treated by some workers in the field, and reserpine (Raurine, Reserpoid, Serpasil) was effective with 34%.

Dr. Millichap and his associates recently reported on a preliminary study of anti-convulsant drugs at The Children's Memorial Hospital prescribed for children whose learning problems were complicated by abnormalities in the electroencephalogram. They found that diphenylhydantoin sodium (Dilantin sodium) caused a significant improvement in a test of auditory perception involving attention, memory, and recall.

Phenobarbital, however, was found to "have variable effects and often exacerbates the hyperactivity," Dr. Millichap reported.

Dr. Millichap recommends starting the patients on the drugs at certain levels and stepping up the dosage over several weeks, observing effects by repeating a battery of neuropsychological tests.

"A relapse in behavior and deterioration in school grades following drug withdrawal are an indication for repeated short-term trials," he counsels. "Long-term treatment can be prescribed, provided that testing is repeated at regular intervals in order to determine the effectiveness of the drugs."

An actometer, an automatically winding calendar wristwatch with the pendulum attached directly to the hands of the watch, is the most useful available mechanical device in evaluating the effect of drugs on hyperactive children, Dr. Millichap says.

The pendulum rotates in a plane parallel to the face of the watch, and movements with a component at right angles to this plane are recorded. The instrument is worn on the wrist or ankle and provides convenient daily readings, indicating excessive movement.

The well can run dry

"When the masses of the people find they can vote themselves prosperity from the public treasury, a democracy is no longer possible."—Socrates.

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"To be or not to be . . .

BY THELMA PEPLOW/SYCAMORE

The words in the title are very short; the longest word has three letters, the word "not." Many will recall these famous words of the great Shakespeare from the equally famous play of *Hamlet*. The quote of these six small words is recognizable to many an ear, even though they do not know where it came from. "To be or not to be" is an expression used by others, just to be using words.

What should these words mean to the Medical Assistant and to the members of the Medical Assistants Association? Let us analyze the first words, TO BE. TO BE, means many things to the Medical Assistant—remember, our association helps to educate the Medical Assistant. TO BE, does not and should not command an authoritative outward demand on others. TO BE for the Medical Assistant means for the good of herself, TO BE able to listen, to listen attentively, to develop remembrance, above all, the concentration of her tongue, being careful to answer questions and remarks intelligently so as not to anger her audience. Her audience can be many or only one person.

TO BE, to some is a way of overcoming an inferior complex. Many Assistants who were timid, shy, unable to meet people in a comfortable manner have been helped through the educational programs the Medical Assistants Association provides. The Assistant becomes interested, becomes involved in discussions, and becomes a part

of the Association. All the time she is teaching herself, overcoming the obstacles that are handicapping her.

TO BE able to help, guide, show kindness, compassion to everyone on an equal basis, wealthy or poor, makes for a better, stronger character; a more humble and appreciative Medical Assistant. There are so many "TO BE's," just thinking about them can expand in developing the character of the Medical Assistant if she so desires it.

NOT TO BE, the longest word "not" is an obtuse word to the Medical Assistant. NOT TO BE can be used in ways not becoming to the Medical Assistant. NOT TO BE a part of an Association, NOT wanting to learn, NOT wanting to see, NOT wanting to hear or participate with other members whose work is similar to hers, NOT TO BE able to find friendships and exchanging of ideas through educational lectures and films are only a few of the "NOT TO BE's" to the Medical Assistant.

The mind needs to learn, to grow, to expand at all times. The NOT TO BE, must be left behind. The TO BE must be pressed forward.

Which is your assistant doctor, the "TO BE" or the "NOT TO BE?"

For information regarding membership in this organization please contact Mrs. Norma Domanic, 150 Ash Street, New Lenox, Ill. 60451 or Mrs. Vivian Kraft, R.R. No. 2, Normal, Ill. 61761.

Meeting Memos

Jan. 2-21—American College of Surgeons

Scientific Winter Cruise, Sectional meetings
55 East Erie St., Chicago

Jan. 7-9—American Cancer Society

National Conference on Cancer of the Colon and Rectum
Hotel del Coronado, San Diego, Calif.

Jan. 8—The Chicago Heart Association

James B. Herrick Memorial Lecture
"The Natural History of Hypertension and Effect of Treatment"
Sheraton-Blackstone Hotel, Chicago

Jan. 13-14—Cleveland Clinic Educational Foundation

Postgraduate course program
"Fifty Years of Surgical Progress"
2020 East 93rd St., Cleveland, Ohio

Jan. 22-24—Arizona Heart Association

14th Annual Cardiac Symposium
Arizona Biltmore Hotel, Phoenix, Arizona

Jan. 27-29—Passavant Memorial Hospital

Memorial Hospital
"The Year in Internal Medicine"
Offield Auditorium, Passavant Memorial Hospital, Chicago

Obituaries

***Jennie K. Amtman**, Chicago, died October 11 at the age of 68.

***Daniel Haffron**, Elgin, died in October at the age of 64. He was former superintendent of the Elgin State Hospital.

***David M. Jenkins**, Bloomington, died September 13 at the age of 67. He was former president of the Illinois Obstetrical and Gynecological Society and past-president of the McLean County Medical Society.

***F. J. Maciejewski**, LaSalle, died at the age of 86 on October 8. He was a member of the ISMS Fifty-Year Club and past-president and past-secretary of the LaSalle County Medical Society.

***William A. McNichols, Sr.**, Dixon, died August 28 at the age of 73. He was past-president and past-secretary of the Lee County Medical Society and a member of the ISMS Fifty-Year Club.

***R. Albert Rutz**, Olympia Fields, died October 13 at the age of 80. He was a member of the ISMS Fifty-Year Club.

*Indicates member of Illinois State Medical Society

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SOCIO ECONOMIC *news*

A service of the Public Relations and Economics Division

BY JOSEPH J. LOTHIARIUS

THE AMERICAN HOSPITAL ASSOCIATION DIFFERS WITH AMA ON "WHAT IS UTILIZATION

REVIEW." The difference was highlighted in a letter from Dr. Thomas H. Ainsworth, Jr., AHA associate director to medical staff presidents and medical chiefs to member hospitals. Dr. Ainsworth's comments were: "The hospital medical staff concept of utilization review is based on the premise that the hospital is not just a facility, but is an organization of physicians, other health professionals, and institutions cooperating in the delivery of health care services to the patient at the community level. Its goal is optimal utilization, not over-utilization nor under-utilization. Thus, it cannot be separated from a complete medical audit of the care the patient receives, which is a medical staff function by peer review."

Dr. Ainsworth goes on to say, "the prime concern of all hospitals is the patient; what is good for the patient is good for the trustee, the administrator and the medical staff—the team concept. Thus, utilization review becomes a management tool for evaluating policy as it affects patient care. While this type of review is a medical staff function—a *review by peers*—it is also a management function, . . ."

"This type of review is not disjointed," adds Dr. Ainsworth. "It reviews admission to the hospital, it is tied to discharge planning from the day of admission, it reviews utilization by diagnosis and age (standards), and in many instances serves as a prospective review before transfer to extended care institutions or home care programs."



INCREASES IN FEE PAYMENTS TO PHYSICIANS ARE BEING PLANNED BY DVR

A fee payment adjustment designed to meet the "usual charges of physicians in the upper two quartiles" is being proposed by the Illinois Division of Vocational Rehabilitation. DVR Director, Alfred Slicer said the new fee plan will become effective January 1, 1971, pending approval by the Bureau of the Budget. Mr. Slicer's announcement comes in response to an ISMS request that DVR start paying usual and customary fees. Mr. Slicer claims DVR has

been paying the "average usual fee of the most common procedures at the 1969 level."

Under the new proposal, the usual and customary fee range will reach charges of the "additional 20% of physicians in those geographic areas where usual charges are above the average level." When Mr. Slicer defines these areas, the information will be passed on to ISMS members.

EACH COUNTY MEDICAL SOCIETY WILL HAVE A CHANCE TO EXPRESS ITS OPINIONS

ABOUT DVR in Illinois on a questionnaire that has been sent to all county society secretaries. The questionnaire, which should be answered by the county society at its next regular meeting, requests physicians to list specific problems with DVR for apparent abuses of the program. County societies can also state their feelings on the adequacy of present DVR eligibility guidelines. The purpose of the questionnaire is to gather pertinent information for the Illinois Bureau of the Budget which is currently studying the DVR program. The ISMS Advisory Committee to DVR asks each county society's cooperation in completing and returning the questionnaires as soon as possible.

AMERICA'S NO. 1 DOCTOR IN THE NIXON ADMINISTRATION MAY SOON BE LEAVING

HIS JOB according to growing rumors (reported in *Washington Report on Medicine & Health*) which are being "vigorously denied" in Washington. Dr. Roger O. Egeberg, assistant secretary of HEW, "has been showing the strains of the demanding job and newly appointed HEW Secretary Elliot Richardson has indicated that, in good time, he would like his own man." Dr. Egeberg, who recently appeared as keynote speaker for the ISMS Leadership Conference, turned 67 in November. HEW insiders say that although Dr. Egeberg doesn't look like a long-term bet to stay on the job, nothing is imminent.

REPORTS TO ISMS ARE INCREASING THAT THE ILLINOIS DEPARTMENT OF PUBLIC AID

IS NOT paying usual and customary fees to physicians. Such reports have just been received from Champaign and Vermilion counties and follow closely on the heels of similar complaints from many other counties in Southern Illinois. IDPA claims it pays usual and customary fees of physicians up to the 70th percentile. This means that—of the approximately 7,000 Illinois physicians treating IDPA recipients—70 per cent of them supposedly are paid their usual and customary fees. IDPA claims it reduces the fees of the physicians in the upper 30th percentile. According to complaints, however, this figure seems high.

A growing number of complaints also accuse IDPA of inconsistencies in claims payments (claims paid vary for the same procedure in the same area and from the same physician).

(Continued on page 639)

The gas/acid group of disorders

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*Slanger, A.: Med. Times 94:150 (Feb.) 1966.

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SPECIALTY REVIEW COURSE IN SURGERY, Part II, Feb. 15
SPECIALTY REVIEW COURSE IN THORACIC SURGERY, March 29
SPECIALTY REVIEW COURSE IN PEDIATRICS, April 19
PROCTOSCOPY & VARICOSE VEINS, One Week, December 14
SYMPOSIUM ON SHOCK, Two Days, December 18
VAGINAL APPROACH TO PELVIC SURGERY, One Week, Dec. 14
BASIC ELECTROCARDIOGRAPHY, One Week, March 8
BASIC INTERNAL MEDICINE, One Week, March 29
CLINICAL NEUROLOGY, One Week, December 7
DIAGNOSTIC RADIOLOGY, One Week, March 22
RADIOISOTOPES, One or Two Weeks, Request Dates
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Information concerning numerous other continuation courses available upon request.

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Hemodialysis

(Continued from page 597)

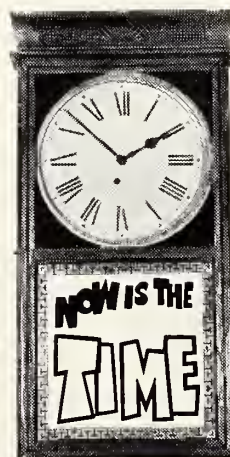
cal advances will continue and that by the end of the 20th century, the kidney machines of our age will be as obsolete as the Model-T Ford. ◀

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Acknowledgment

I wish to thank Mrs. Ruth Schreiner and Dr. R. F. Sondag, M.D., M.P.H. for their help in the preparation of this paper.



... to set

May 16-19 aside for the annual ISMS convention.

ESSENTIALS OF OPHTHALMOLOGY

ROLAND I. PRITIKIN



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EDITOR'S NOTE

The purpose of this printing is to make available a book that serves a worthwhile purpose. Part of that purpose is to point up the changes that have occurred during the past two decades, allowing comparison with the old.

It is fitting that such a book should be authored by Roland I. Pritikin, M.D. A member of more societies than we could list on this page, this man has helped in staffing missionary hospitals and teaching students of ophthalmic surgery around the world. Yet the most significant achievements were those of everyday practice in which he has spent these last two decades, sharing in and contributing to the changes that have made a great specialty much greater.

Dr. Pritikin has honored me by asking for my editorial comments.

Eugene V. Grace, M. D.

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Community health effort—means to an end

This doesn't mean that a large university, like Yale, should immediately accept the full responsibility for all the health care of the city it inhabits, but it does mean that representatives of the university must sit down with members of the community—with sleeves rolled up, so to speak—and join in the CHP effort: give guidance, hear out the problems as they exist and are presented, and put some of their best scholars to work on devising and, at times, actually carrying out more effective means of meeting community needs.

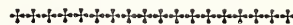
None of this is intended to be an assault on Yale, I hasten to add; these recommendations apply nationally. As a matter of fact, Yale University is more deeply involved through its department of a prepaid group-practice plan for the New Haven area. (Similar plans are being developed by Harvard and Johns Hopkins in their areas.)

It seems to me that, sooner or later, we shall all have to recognize that the crucial point about Comprehensive Health Planning, on which will depend the verdict rendered by our great-grandchildren, is whether or not it actually solved unmet health needs, as it sought to meet the immediate wishes of citizen groups in the search for political relevance. Health is all too often used as a means to some other end, but the test of success to physicians must eventually be "health as an end unto itself." (George James.: The Comprehensive Health Planning Program. *Medical Opinion & Review* (Sept.) 1970, pages 44-45, 49.)

THE TOTAL BILL FOR PERSONAL HEALTH CARE IN THE UNITED STATES IN 1969 WAS

\$52.6 billion, according to statistics just released from HEW. Of this total, the aged (65 years and older) received six times as much in per capita expenditure as did the nation's youth (under 19 years) and two and one half times as much as those persons in the intermediate age group. Differences in the amounts spent for medical care of the three age groups varied considerably with type of expenditure.

Per capita hospital care expenditures for the aged were more than 12 times those of the young and more than two and one half times those for the intermediate age group. For physicians' services, the average expenditure for the aged person was three times that for a youth and less than twice that for a person in the intermediate age group.



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VIEW BOX

(Continued from page 588)

DIAGNOSIS: 3. Tuberculosis (Fig. 3)

The PA chest revealed an alveolar type infiltration with suggestion of cavities in both upper lobes and bronchogenic spread down through the right lower lobe and into the left mid-lung field. The point of interest in this case is rather subtle. You will note that the paravertebral shadow on the right at the level of D-10 and D-11 is displaced somewhat laterally. It is distinctly outlined on the left as well in a displaced fashion. Figure 2 demonstrates definite displacement of the paravertebral shadow on the left as well as the region of D-11 and D-12, which indicates that there is evidence of a paravertebral mass. Figure 3 demonstrates a marked narrowing in the intervertebral disc space between D-11 and D-12 with some loss of bone substance on the anterior-superior aspect of D-12, which is indicative of a Pott's abscess associated with tubercular involvement of the dorsal spine.

It is important to recognize certain lines which are visible within the mediastinal contour on a well-exposed PA chest, since deviations and their pattern may supply important clues to the presence of disease. The reflection of the pleura from the posterior thoracic wall onto the right side of the mediastinum is smooth and uninterrupted by protruding structures except for

the right atrium, the superior vena cava above, and the inferior vena cava below. It is invisible, therefore, on PA films of the chest. By contrast, on the left side the descending thoracic aorta protrudes slightly laterally in the posterior mediastinal compartment causing a lateral displacement of the mediastinal pleura posterior to it. This creates the paraspinal line. It consists of a longitudinal density projected about midway between the outer border of the descending thoracic aorta and the vertebral column extending from the aortic arch above to the diaphragm below. Some of the reasons for deviation on this shadow may be: 1) Infections of bone, such as tuberculosis and vertebral osteomyelitis with soft tissue extension displacing the vertebral shadow; 2) Metastases in the dorsal spine with extension out into the soft tissues; 3) Dissection of the thoracic aorta with hematoma extending laterally; 4) Fracture of the dorsal spine with paravertebral hematoma; 5) Enlargement of the lymph node chains extending up from the retroperitoneal space; and 6) Enlargement of the hemizygous system for purposes of collateral pathways. The importance of observing the paravertebral line as a first clue to serious underlying pathology is demonstrated.

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GENERAL PRACTITIONER WANTED to join four General Practitioners' Group in young suburban community of 100,000. Tired of long hot summers—cold winters alone on call? Move to San Francisco Bay Area—mild climate. Must have California license and no military obligations. Forty-five minutes from downtown San Francisco. Salary leading to partnership. Contact Phillip M. Loeb, M.D., Center Medical Group, 2190 Peralta Blvd., Fremont, California 94536, Telephone 793-2645.

UNUSUAL OPPORTUNITY FOR PHYSICIANS who wish to supplement a young practice or teaching position or who prefer not to maintain an office to join a rapidly growing fee-for-service group in the Emergency Departments of Chicagoland hospitals. Flexible work schedules, 16-48 hours weekly. Prefer surgeons, general practitioners with experience in traumatic medicine, or those specifically interested in high standard Emergency Care. Group is expanding, developing teaching programs. Excellent facilities, automated billing and collecting service, opportunity for research in emergency procedures and programming. Ideal for physician desiring high remunerative compensation for circumscribed work. Address reply to: Medical Emergency Service Associates (MESA), S.C., 111 North Addison, Elmhurst, Illinois 60126. 832-4504.

URGENTLY NEEDED: General Practitioner, Orthopedic Surgeon, Otolaryngologist, to supplement staff of nine man multispecialty group. Beautiful new building with space available, located across street from new five-hundred-bed hospital. Suburban location, but only 30 minutes from downtown Chicago. Generous starting salary, and partnership after two years. Contact Mr. G. A. Caress, Manager, Pronger-Smith Clinic, 2320 W. High Street, Blue Island, Illinois 60406, Phone FULTON 8-5500.

NEW EXPANDING OPPORTUNITIES for family physicians and physicians specializing in pediatrics, internal medicine, anesthesiology; in medically-awakening community. Contemporary, automated, 105-bed, new hospital to be completed in the fall of 1970. Present hospital to be converted into long-term unit. Patient service area 50,000 people. Medical staff leading and supporting recruitment efforts. Excellent community location, forty miles equidistant to Milwaukee or Madison. Complete educational, cultural and recreational facilities. A new medical-dental building and a 130-bed skilled care nursing home being constructed adjacent to the new hospital ready for occupancy January, 1971. Immediate satisfaction in practice, income and family living. Special assistance if needed. Write or call Paul R. Glunz, M.D., Watertown Memorial Hospital, 1301 E. Main Street, Watertown, Wisconsin 53094. Telephone 414-261-4210 for more information.

FOR SALE, LEASE OR RENT

FOR SALE: General Practice, Chicago Northwest Side, established 28 years, full equipped, net over \$40,000. Retiring. Nominal cash, terms to suit. Call (312) 252-0494 or write Box Number 781, c/o Illinois Medical Journal, 360 N. Michigan Ave., Chicago, Illinois 60601.

GENERAL PRACTICE for sale. Desirable Chicago suburb. Excellent 450-bed hospital, 3 blks. from office. Over \$60,000 net. Call (312) 834-6084.

FOR RENT: Lake Forest, Illinois. Office space available in new air-conditioned Medical Building in center of town. Elevator and excellent parking facilities. Call Dr. E. Kadison—Telephone 295-1220.

FOR RENT: Physician's office for one or two physicians in modern downtown building, ground level location with parking facilities, West Chicago, Illinois. Full equipment available, for rent or option to buy. Three hospitals in eight mile radius. Area desperately needs physicians in all categories of practice. Please correspond: KJK CORPORATION, 27 Cass Street, Lemont, Illinois.

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